State of Maryland / Department of Health and Mental Hygien@ [] [] 5 3950 I 1 - For Stete Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year December 4, 2006 **Physician** 10:15 PM Katherine C. Evans /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore Charlestown Care Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yee 7/7/191 9. Birthplace (State or Foreign Country) New Jersey Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 🗷 F Director 95 Yrs. 242**-**36-8547 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 U.S.A. 707 Maiden Choice Lane Apt. 8113 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry ring most of working d 2 should be filed within 7 th and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Medical L Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alva Daughterty John F. Cross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 is Department of Health ar Important: If item 27 is any injury or other treu once. 711 Maiden Choice La. #1208 Catonsville, MD 21228 Eileen K. Barth - Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/8/2006 Woodlawn, MD '4 □ Donation 5 Ø Other (Specify) Entombment Lorraine Park Witzke Edmondson 22. Name and Address of Facility Sterling-Ashton-Schwaffuneral Home of Catonsville, Inc. 163 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate case. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): led by the attending physician and detached for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown After this certificate has been signed funeral director, page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2₽No I or Attending Physician: after death. Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred Certification; 5 Pending investigation Injury 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel o within 24 hours aft To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DC6266 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) in Chiric Cam, all 31. Date filed (Month, Day, Year)
DEC 1 2 2006 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 10 AM JESSE JAMES EDISON /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 124 W. FRANKLIN ST. APT 303 BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 □ F PENNA Director 80 10-28-1926 160-20-1628 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits ns 23a or 28a-f show must be notified at N/A BALTIMORE MD. 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 124 W. FRANKLIN ST. APT 303 21201 USA Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 🖾 No Specify þ 3 Widowed 4 Divorced Completed 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -0--6-LABORER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 ENOCH EDISON MYRTLE EDISON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health at: If Item 27 is MICHAEL D.\_EDISON(NEPHEW) 7600 SEVEN MILE LANE PIKESVILLE, MARYLAND 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ femation 3 □Removal from State Department of important: If any Injury or once, 12-11-2006 METRO CREMATORY BALTIMORE, MARYLAND 4 Donation Other (Specify) HIBN R2. Name and Address of Facility PHILLIPS FUNERAL HOME. P.A. 21. Signature License TONATHAN 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, to heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a con a quence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and stree burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Nown Completed 46. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. lace of Death Check only ope) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No Certification: To 4 
Nursing Home 5 Residence 6 □Other (Specify) 27. Man or of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation Injury s after dec. ral Director: After 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L

Registrar DHMH 17 Rev 1/2001

State

29a. Certifier

(Check only

RV

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

at Abous

2006

Mn

Registrar's Signature

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

			-	State of Marvlar		ent of Health and	•	_	
			1 - For State Registrar		·	ate of Death		No 2006	39503
	94,		1. Decedent's Name (First, Middle, Last	)	1-1	- 4	2. Date of Death		3. Time of Death
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature Funeral Service Licens	ee /// //	22. Name	and Address of Facility	2879 44	DSED	57.
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89 )	The law requires that the death certifical ite has been signed by the ettending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE:						
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	1		30. Name and address of person who c	and the second s	m 23a) (Type, Print)				
			Mohamed Yassin	821 N	Eulaw	* 308 Ba	ltimore-1	41) 2120	1
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Fletcher, Belinda

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physician	n/	Registrar 1. Decedent's Nam	e (First, Middl	e,Last)			-			2. Date of De	eath		3. Time of Death
Medical Examin		JULIAN CLA									er 7, 2006	ear	0625 hrs
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Funeral		5. Social Security N	lumber	6. Sex	7. Age	e (In yrs. last	birthday)	If Under 1 Yea			Birth (MM/DD/YYY	Y) 9 Birt Foreig	
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Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status				Ever in U.S.		s Decedent of His		( Specify Yes or I	No- 14. Rac		can Indian, Black,
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Division of Vital Records, ral or Attending Physician: The law require rs after death al Director: After this certificate has been side in by the funeral director, page 2 should be the funeral director, page 2 should be the funeral director, page 2 should by the funeral director, page 2 should be the funeral director and the	Certification:	3 Suicide	6 Coul	d not be 28e. F	Place of In	ury - At hom	e, farm, stree	et, factory, office b	ouilding, etc.	28f. Location or Town,		per or Rur	ral Route Number, City
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DHMH 17 Rev 1/200	01					-	ORIGINA						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 8, 12:47 A 2006 Leon Carter Faidley December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7 Schoolhouse Ave APT 7 Westminster Carroll If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 € M 2 □ F Hours 64 **Director** 212-38-5505 March 16, 1942 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene. It was 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Carroll MD Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 Schoolhouse Ave APT 7 21157 United States Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Custom Applicator Meyers Fertilzer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carl Faidlev Audra Elizabeth Meyers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4329 Orleans Rd. Great Cacapon, WV 25422 19a. Informant's Name/Relationship (Type. Print) Kelly Crumbacker (daughter) permit. Pages 1 a Department of Hes Important: If Item any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/12/2006 Grantsville Cem. Grantsville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Furrier-Queen Funeral Home and Crematory, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately 1212 W. Old Liberty Rd. Winfield, MD 2178/1 Approximately 1 Approximate Interval Between Onset and Death Immediate Cause (Final Pancreatic CA with Meturen **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dusito (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 2/71 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No Certification: To 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending investigation after death, I Director: Ald in by the fu 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and of investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of pertifier 29c. License number

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State Registrar 30. Name and address of person who complete

DEC 12

2006

Alexander Box

31. Date filed (Month, Day, Year)

d cause of death (Item 23a) (T) pe, Print)

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Begistrar's Signatur

n 37auc

21157

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year , 2000 DECEMB 4a. Facility Name (If not institution, give street and number, 4b. City, 4c. County of Death OYKIN ocial Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 XM 2 ☐ F 11 Yrs. 215-43-2755 Usual Residence of Decedent 09 94 MD 10a. State 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 3411 Carisle Ave 21216 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7th grade Home Schooling Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shavonne Mahanmad Clarence Joseph 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3411 Carisle Ave, Baltimore, Md Clarence Joseph-Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Marial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) Memorial Park 12/1206 Randallstown, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, 21215 23a. Part1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic morath( Kenal Due to (or as a consequence of): Kena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit Physician/Medical þ Completed 2 Be Certification: To Medical

Division or Vital Records, P.O. Box 68760

not applical	,	1 Yes 2 No 3 Probably 4 Unknown				
,				24a. Was an autopsy performed? 1□ Yes 2□ No  24b. Were autopsy findings available prior to completion of cause of death? 1□Yes 2□ No		
25. Was case referred to medical			26. Place of D	eath (Check only one)		
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 4 Impatient 2 [	☐ER/Outpatient 3☐	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. Manner of Death 1 ☑ Matural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred		
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injury - At I building, etc. (Spec		tory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one)	nysician: To the best of my kr miner: On the basis of examir and manner stated.	nowledge, death occurr nation and/or investigat	red at the time, date and pla tion, in my opinion, death oc	ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)		

29c. License number

Kes

29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address

2006

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print)

NOIF

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

21215 Approximate Interval Between Onset and Death DAYS DAYS 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown autopsy performed? 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 57. AGNES HOS MITAL AM AVE BALTIMORE MD 31229

10:12 AM

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

1 ☐Yes 2XNo

2006

U.S.A.

14. Race - American Indian, Black, White, etc.

Specify: Black

House

Hospital or Attending within 2

Registrar

29b. Signature and title of certifie

KR IS M. SA 31. Date filed (Month, Day, Year)

SHE

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XAMI 900 22. Registrar's Signature

29c. License number

D0037359

			1 - For State Registrar	State of	Marylar				ealth a Death			Reg. No	2111	) 6	395	808
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	Funeral		Stella Maris Hosp 5. Social Security Number 6. S	ex 7	Age (In yrs.	last birthday)	If Unde	r 1 Year	If Under 2		8. Date of Bir	th		O Diete	lace (State o	r Foreign
	Director		214-16-3298	M 2□F	87	Yrs.	Months	Days	Hours	Min.	1a $\overset{(M^{onth},}{1}$	r, rear	919	Coun	Mary Mary	land
Т	g .		Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or Lo	ocation								0d. Inside Cit	
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	the N 28a-f	ect	MD Baltimor	е	1 1111	OTTUIII	10f. Z	p Code				10g. Cit	izen of W	hat Coun		
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	n 72 hours after death with the Marylan "naturel", or lieme 23a or 28a-f ehow salicel Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Deced Armed Ford	ent Ever in U	J.S. 13.	Was Dece	dent of Hi	spanic Orig	gin? (Spec	cify Yes or No Rican, etc.)	)-		- Americ	an Indian,	
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A	41/		30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type,	, Print)									
	, A	ata.	DR. TARTO MAHMOO 31. Date filed (Month, Day, Year)	32/Re	gistrar's Sign	EY VALI			'IMONI'	LUM,	MD 210	93				
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DECEMBER 10, 2006 12:50 p.m.

ANDREW FINN

			For State	State of Marylar	•		Mental Hygie	ne	00500
			Registrar  1. Decedent's Name (First, Middle, L.	est)	Certifica	ate of Death	Reg.	No.'	3. Time of Death
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	/Medio Examir		4a. Facility Name (If not institution, gir		4b. Ci	ty, Town, or Location of De		4c. County of Death	
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	Funeral			Sex 7. Age (In yrs	3 & Month	der 1 Year   If Under 24 H		ar) 9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent	8	3 Yrs.		March 25	,1923 i	intry)
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits
	Many Fr	ţ	Maryland Bal	timore /	Bultim	ore			1 ☐ Yes 2 No
	or 28s	Director	10e. Street and Number	/ X	10f.	Zip Code	10g.	Citizen of What Cou	ntry?
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	er des	nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was De If Yes, s	cedent of Hispanic Origin? pecify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White	
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land	be fill bd out even	Be	17. Father's Name (First, Middle, Las	_		18. Mother's N	ame (First, Middle, Maid	fen Sumame)	
3	should be nd Mental marked c	2	19a. Informant's Name/Relationship	agan	10h Mailia Adda	Rat	12 16as	<del></del>	0.41
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<u>a</u>	permit. Pages 1 and Deportment of Health Important: If Item 27 any Injury or other tr ance.		20a. Method of Disposition	20b.	Place of Disposition (#	Name of		Location - City or T	
Baltimore	Pages nent of int: If It		1 Burial 2 Cremation 3 ( 4 Donation 5 Other (Spec	IBemoval from State	cemetery, crematory c hutus "Me	- 1	14106 B	Salta MI	
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П			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the dea one cause on each line.	th. Do not enter the m	node of dying, such as cardi	ac or respiratory arrest,		Approximate Interval Between
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oʻ	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a consec	quence of):				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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9	death certifica ettending ph d for use as th	Med	IF FEMALE:						
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_	the e	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o 9□ Unknown	death 5 ☐ Other	(specify)		lilione.	Day Toda
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	Jing P. After t funera		27. Manner of Death 1 2 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	jury occurred	
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Division	f or Atten after deat Director: in by the	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fact fy)	ory, office	28f. Location (Street City or Town, St	and Number or Hurs ate)	al Route Number,
_	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certifical completely filled in by the funeral director.		29a. Certifier 1 Certifying P	nysician: To the hest of my kno	owledge, death incum	ed at the time. date and we	Qu. 30d dua to the cause	(s) and mannar as =	Hates!
	n 24 t n 24 t ne Fui	Medicai	(Check only 2 Medical Exa	miner: On the basis of examina and manner stated.	ation and/or investigati	on, in my opinion, death oc	curred at the time, date a	and place, and due t	o the cause(s)
	To the Comp	ž	29b. Signature and title of certifier		1	29c. License number		Date signed (Month,	•
,	1		MHaron	DMD		D56418	De	cember	9,2006
	U		30. Name and address of person who	complet of cause of death (Item	m 23a) (Type, Print)	D56418 unt Road	0	\	0 21127
V			K. TOMA Mas  31. Date filed (Mohth, Day, Year)	on M) 540	ol Old co	unt Koad,	Kandalls	town M	1)21133
	Sta Registr		ner 1 2	32. Registrar's Signature 2006	D. Com				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

Robert Lee Guernd	t Si	ate of Maryland		nent of cate of		Mental H		2.0	06 2051
Physician/	Registrar  1. Decedent's Name (First, Midd	e,Last)					2. Date of Deat		3, Time of Death
	Robert Lee Gu	erndt Jr.		-1-			Month December		1823 hrs
The state of the s	4a. Facility Name (if not instituted 2106 Marsh Rd	n, give street and number)		4	o. City, Town, or I Essex	ocation of Death	1	4c. County of [ Baltimore	
Funeral	5. Social Security Number	6. Sex 7. Ag	e (In yrs. last b	oirthday)	If Under 1 Year	If Under 24Hrs	_		9 8irthplace (State or
Director	214-58-7024	1 XM 2 F	50	Yrs	Months Days	Hours Min	08/22/	1956	CountryMaryland
any	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Locatio	n .				10d. Inside City Limits
nd show a	Maryland Balti	more	Essex						1 Yes 2XXNo
Maryland 28a-f sho d at once	10e. Street and Number				10f. Zip Code		10	Og Citizen of What	Country?
th the N 23a or 2 notified	2106 Marsh Road				21 221			U.S.A.	
death with or items 23. nust be no 'uneral	11. Marital Status 1 Never Married 2 XXM	12. Was Decedent Armed Forces?			Decedent of Hisp s, specify Cuban,			- 14. Race - A White, e	American Indian, 8lack, etc.
iffer de	3 Widowed 4 Div	orced If Yes, Give Year	X No	1	Yes 2XX No	specify		Specify:	White
hours aft natural Examine ed by	15. Decedent's Education (Spe				s Usual Occupati			16b. Kind of Busin	ness/Industry
OO36 within 72 hour giene her than "natu her than matu o Medical Exar	Elementary/Secondary (0-12)	College (1-4 or 5	· .	Crane	Operato:	r		  Chemical	. Company
5-0036 led within 7 Hygiene I other than the Medica	17. Father's Name (First, Middle	Last)					e (First, Middle, N	Maiden Surname)	- compa-1 <sub>1</sub>
2121 ould be fil Mental H marked ic event,	Robert Guerndt  19a, Informant's Name/Relations	No. of the second		Ob. 14-11'	A.1.1		Hofste		
D show and it is	Jean Guerndt (V							nber, City or Town, S Maryland	
e, M I and 2 Health Titem 2	20a. Method of Disposition		20b. Place		ion (Name of cem		Date	20c. Location - Ci	
MOr Pages nent of ant: H	1 X 8urial 2 Cremation 4 Donation 5 Other S		110	yHill	Mem. Ga:				e, Maryland
Baltimore, permit Pages I a Department of He Important: If ite	21 Signature of Funeral Service	Licensee		22. Na	me and Address Bru	of Facility Zdzinski	Funera	l Home, F	P.A. 3 04004
Physician	23a Part Enter the disease, or	complications that caused	the death. Do	1.40	) OTA Pa	SCETII E	venue,	rosex, Ma	aryland 21221 Approximate Interval
/Medical	failure. List only one cause Immediate Cause (Final disease		erotic ca	ardiova	scular dis	ease			8 etween Onset and Death
Examiner	or condition resulting in death)	Due to (or as a conse		ar drove	ocurur dir	<u> </u>			
Jer.	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):						
A sed nisit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a conse	equence of):		<del></del>				
	events resulting in death) Last	d		\ <u></u>					
0, bob evecuted e be evecuted burial - transi	X UNPENDED	X AMENDED #2,	sa,27,per perME, g	ME, g86 862, 12	3, 1/2/07 /19/06 TT	TT			
	IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	23c. If yes, outcome 1 Live birth	ne of pregnanc		al death 3	Ectopic pregna	ancy	23d. Date of de Month	livery Day Year
ather ath	1 Yes 2 No 9 Un		time of death		er (Specify)				
D. Bo tribe de by the ached f	Part II. Other significant condi	ions contributing to death	but not result	ing in the ur	derlying cause gi	ven in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
P.O. res that the signed by be detac							1 Yes	2 No 3	Probably 4 🗸 Unknown
ords  * requi s been should							24a. Was a autop	sy prio	re autopsy findings available or to completion of cause of
Division of Vital Records, all or Attending Physician: The law require reafter death.  al Director: After this certificate has been six led in by the funeral director, page 2 should be artification: To Be Completed							perfor 1 Yes		th? Yes 2 No
ital Recitions: The scerificate rector, page	25. Was case referred to medica examiner?	Hospital. 1 Inpatie	- 2 ED/	Outpatient		of Death (Check		Residence 6 🗸	04
I of V ding Phys After thi funeral di	1 ✓ Yes 2 No 27. Manner of Death	28a Date of Inju	ry 28b	Time of In	O DOA	/ at Work?		now injury occurred	Other Scene
Ision of Attending r death. ector: Afte by the fune ication:	1 X Natural 5 Pen 2 Accident Inve	(Month, Day, Y ding stigation	ear)		1 Y	es 2 No			
Division pital or Attend ours after death reral Director: filled in by the f	3 Suicide 6 Cou	d not be 28e Place of In	jury - At home,	farm, street	, factory, office bu	ulding, etc.	28f. Location (S or Town, St		or Rural Route Number, City
D To the Hospital within 24 hours Worthe Funeral completely filled edical Cer	4 Homicide  29a Certifier Certificing R	mined (Specify) hysician: To the best of m	v knowledge d	leath occurr	ed at the time, dat	e and place and	I due to the caus	e(s) and manner as	: stated
To the Hos within 24 h To the Fur completely		miner: On the basis of examiner and manner stated							
Me Me	29b Signature and title of certifi	er			29c. License				(Month, Day, Year)
W W		W, MID			O.C.N	1.E.		December 8,	2006
18.63	30. Name and address of persor Ling Li, MD Assista	who completed cause of dent Medical Examine			, Baltimore, N	/ID 21201			
State	31. Date filed (Month, Day, Year)		r's Signature		ast s				

DHMH 17 Rev 1/2001 OCME 2006

10K PRINTS

ORIGINAL

06-09394 Deborah Giant

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar		cate of Death		Res	g. No. 200	6 3051			
Physicia Medical Exami	41.07	Decedent's Name (First, Middle,Last)     Deborah Kay Gi	lant			2. Date of Death Month December		Time by Death 17438 hrs			
zako		4a. Facility Name (if not institution, give		4b. City, Town	, or Location of Death		4c. County of Deatl				
		Lee Airport		Edgewat			Anne Arundel				
Funeral Director			7. Age (In yrs. last bi		Year If Under 24Hrs Days Hours Min	<b>-</b>	(MM/DD/YYYY) 9. Bir Foreig 1956				
any	}	Usual Residence of Decedent  10a State 10b County	10c. City, Tow	n or Location	-			10d Inside City Limits			
and show	'n	TX Brazos	Colleg	ge Station				1 Yes 2 No			
th the Maryland 23a or 28a-f show any notified at once,	Director	10e Street and Number		10f. Zip Cod		10	g Citizen of What Cou	_			
ith the 23a or		3924 Tranquil Path Dr	12. Was Decedent Ever in U.S.	77845		asif . Vac as Na	US	A ican Indian, Black,			
eath w items	Funeral	1 Never Married 2 Married	Armed Forces?  1 Yes 2 X No	13. Was Decedent of If Yes, specify Cu	iban, Mexican, Puerto		White, etc.	ican indian, black,			
after d	by F.	3 Widowed 4 N Divorced	f Yes, Give Year or Dates:	1 Yes 2 X	No specify:		Specify: Whi	te			
72 hours after death with the Maryland n"natural", or items 23a or 28a-f she al Examiner must be notified at once	ed t	15. Decedent's Education (Specify only	highest grade completed) 16a	<ul> <li>Decedent's Usual Occu during most of working</li> </ul>		tion (Give kind of work done DO NOT use retired) 16b. Kind of Business/Industry					
36 hin 72 e than "	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+) +3	ollections N	Manager	anager Banking					
15-0036 filed within 72 I Hygiene ed other than ' t, the Medical		17. Father's Name (First, Middle, Last)			18.Mother's Name						
21215-0036 July be filed within 7 Mental Hygiene marked other than ic event, the Medica	Be	Billye Frisch  19a Informant's Name/Relationship (Ty)	ne Print \	9b. Mailing Address (S	Frances	-	or City or Town State	Zin Codo)			
AD 2 2 shoul 27 is n matic	2	Frances Frisch		.025 Brandyv				, zip code)			
imore, MD 2 Pages I and 2 shoument of Health and I rant: If item 27 is roor or other traumatic		20a. Method of Disposition		of Disposition (Name of atory or other place)	cemetery,	Date	20c. Location - City or	Town, State			
Pages ment of ant: I or oth		Burial 2 Cremation 3 Other Specify:	I Cellioval II offi State	ay Jones Chama	- 1	16/2006	Bryan, TX				
Baltimore, MD 2 permit Pages I and 2 shou Department of Health and Important: If item 27 is 1 injury or other traumaric	ſ	21. Signature of Funeral Service Licens	M01378	22. Name and Add Gary L. R	Kautman Fu	neral Ho	me at MMP,	INC.			
Physician		23a. Part. Enter the disease, or officer	cations that caused the death. Do r				ridge, MD st, shock, or heart	Approximate Interval			
/Medical	I	Immediate Cause (Final disease a N	h line. Nultiple Injuries					Between Onset and Death			
Examiner		or condition resulting in death)	ue to (or as a consequence of):								
	ē		ue to (or as a consequence of):								
	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated	ue to (or as a consequence of):								
cuted nd transit		d									
760, icate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED #3, perME, s	g863, 1/24/07	TT						
8760, ificate be ag physic sthe bur	- 1	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnancy	y <sub>2</sub> Fetal death	3 Ectopic pregna	ancy	23d. Date of deliver	y Day Year			
Ox 687 eath certific	sician	past 12 months?  1 Yes 2 No 9 V Unknown	4 Pregnant at time of death	5 Other (Specify)		,		· .			
he dy the	Phys	Part II. Other significant conditions	9 Unknown	ing in the underlying cau	se given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?			
P.O es that t igned by	Š				9	1 Yes	2 No 3 Pro	pably 4 Unknown			
of Vital Records, Pig Physician: The law requires to the this certificate has been sign neral director, page 2 should be to	Completed					24a. Was a		itopsy findings available completion of cause of			
Reco The law cate has	omo					perform 1 🗸 Yes 2	ned? death?				
tal Recitan: The certificate	Be	25. Was case referred to medical examiner?		26.P	lace of Death (Check						
of Vita ig Physicia fter this cel	2	1 Yes 2 No		Outpatient 3 DOA  Time of Injury 28c.	Other Nursin		Residence 6  Othe	r: Scene			
ion of \ tending Phyeath. tor: After the	tion:	1 Natural 5 Pending	Dec 9, 2006 173	00 5		Plane crash	on injury occurred				
Division tal or Attendi rs after death. al Director: /	ficat	2 Accident Investigation 3 Suicide 6 Could not be	28e Place of Injury - At home	farm, street, factory, offic	ce building, etc.			iral Route Number, City			
Divisity or At spital or At tours after d acral Direct filled in by	Certification:	4 Homicide determined	(Specify) Ravine near ai	irport		or Town, St. Lee Airport, Ed					
To the Hospital within 24 hours To the Funeral completely filled			<ul> <li>n: To the best of my knowledge, de</li> <li>On the basis of examination and/or</li> </ul>								
To t with To t	Medical	29b. Signature and title of certifier	and manner stated		ense number		29d Date signed (Mo				
_ <	50	Jash Ja	elMO	0.	C.M.E.		December 10, 20	006			
100		30. Name and address of person who co				l					
· · · ·			ssistant Medical Examiner	111 Penn Stre	et, Baltimore, MI	21201					
St Regist	tate trar	31. Date filed ( <b>DE</b> C <sup>D</sup> a1, Y2'') 2008	Registrar's Signature	GOSALI)							

			1 - For Amend #8	Per FH	G862	271978 Ce	artmer frificat	nt of H	lealth a Death	and Me	ntal Hyg	iene2	006	3951	2
			1. Decedent's Name (First, Middle,								Date of Dea Month		Year	3. Time of Death	
	Physicia /Medic		Ellen N.	rove							Pec	08	2000	1204 A	A
)	Examin	er	4a. Facility Name (If not institution, g			1			Location of				inty of Death	_	
_			Howard Coun :  5. Social Security Number 6	Sax Gene	7. Age (In yrs	B Spi ta	) If Unde	r 1 Year	m DI		. Date of Birth		0 Wa	place (State or Foreig	an an
	Funeral Director		220-56-1845	1 □ M 2 □XF	54	Yrs.	Months	Days	Hours	Min. D	Date of Birth (Month, Day CC • 20	, Ye 1951	⊢ Ma	ryland	
	ס		Usual Residence of Decedent		10.0									40d taxida City I imit	_
	arylar show	_	Maryland N/A			ity, Town or L Baltimo								10d. thside City Limit. 1 ☑ Yes 2 ☐ N	
	the M	Director				arcino		n Code			1	Og. Citizen	of What Cor		_
	3e or	ום	300 5th Ave.				2	1227				USA	A	,	
000	should be filed within 72 hours after deeth with the Maryland Mentel by Wilson.  Marked other than "natural", or lieme 23s or 28s-f show marked other than "natural", or lieme 23s or 28s-f show marke ovent, the Modical Examiner mast be notified a	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Dec Armed F 1 1 Yes If Yes, G Year or	cedent Ever in l forces? 2 X No live Dates:	U.S. 13.	. Was Dece If Yes, spe	cify Cuba	ispanic Ori in, Mexicar Specify:	n, Puerto Ri	ty Yes or No- can, etc.)		Race - Amer Black, White ecify:		
3	2 hou	ted	15. Decedent's	Education		16a. Dec	edent's Usu	al Occup	ation	d of working		16b. Kind o	f Business/I	ndustry	_
7	thin 7 e.	Completed	(Specify only highest Elementary/Secondary (0-12)		(1-4or 5+)	life.	odian	ise retirec	during mos d)	t of working		Cuat	odial		
7	ygien ygien rer th	Con				Gust	ouran		40 14-45	-1- N /	F: A #				_
	permit. Pages 1 and 2 should be filed within Department of Headle and Marken tellar Hipportant: If Itam 27 is marked other than eny injury or other treumatic event, Itam Marken DDG.	To Be	17. Father's Name (First, Middle, La Walter Cody	ist)						ah Be	First, Middle, I ntly	Maiden Sun	name)		
Mar	d 2 sho th and ! 7 is ma treums		19a. tnformant's Name/Relationship Bruce P. Grove		d		ling Addres 5th				Route Number e, MD.	r, City or To	_	ip Code)	
e,	of Heel of Heel fitam 2 ir othar		20a. Method of Disposition  1 ☐ Buriat 2 ☐ Cremation 3		20b.	Place of Disp cemetery, cre KeV1.eW	osition (Na	me of		Dat	e	20c. Location	on - City or		
paltimor	t. Pag tment tant: I tjury o		4 □ Donation 5 □ Other (Spe	cify)	La								ldge,	MD	
מ	Departiment in poor		21. Signature of Funeral Service Lin	1	>						e, Inc		.a MD	21227	
<b>\</b>	Physician		23a. Part1. Enter the disease, or or shock, or heart failure. List or tramediate Cause (Finat disease or condition	lly one cause on	caused the dealeach line.  Rondo (or as a conse						respiratory arr	AF DU EU est,	IS, MI	Approximate Interval Between Onset and Death Months	
į	/Medical Examiner		resulting in death)	Due to	o (or as a conse	equence of):									
	pe sit	lner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	b	o (or as a conse	equence of):									_
ĵ	certificate be executed Iding physician and ise as the burial-transit	Examiner	that initiated events resulting in death) Last	c	o (or as a conse	equence of):									
04/p	cate be physici the bu	dical		d					<u> </u>						
O. BOX 6	death e etter ed for u	Physician/Me	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	1 ☐ Live	utcome of pregr birth 2 Per gnant at time of nown	tel death 3	□Ectopic p		,			23d.	Date of deli Month	very Day Year	
S.	law requires that the as been signed by th 2 should be deteche	by Ph	Part II. Other significant condition											the cause of death?	
ecora	requir een si	ted	Chronic o	botruc	hre	rul	mun	ary	1/15	euse	107			obably 4 Unknow	
итан жес	The lar	Completed									24a. Was a autop: perfor 1 Yes	an 24 sy med? 2 1 No	death?	topsy findings availab completion of cause of 2 No	le
<b>VII</b>	Physician: r this certific ral director,	Be	25. Was case referred to medicat examiner?	Hospital:		7550		o. Oth			Check only or		a		
0	Physical Physical Colored Physical Color	7. 70	1 ☐ Yes 2 ☑ No  27. Manner of Death		Impatient 2 ( e of Injury onth, Day Year)	☐ ER/Outpation 28b. Time		28c. Injur Wor			e 5 ☐ Resid			ary)	
<u></u>	nding ath. r: Afte e func	atlor	1 Naturat 5 ☐ Pending 2 ☐ Accident investiga		inth, Day Year)	Injury	М		k? Yes 2∐	No					
UIVISION	after des Directo	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad   288. Plat	ce of Injury - At iding, etc. (Spec	home, farm, s	street, facto	ry, office		28	f. Location (S City or Tow		umber or Ru	ral Route Number,	
	To the Hospitel or Attending Within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C		Physician: To the caminer: On the and ma											
	To The state of th	ž	29b. Signature and little of certifier	-			29		e number		2	29d. Date si	gned (Monti	n, Dey, Year)	
)	(1)		# Tweek	- M	D			V 42	892	2		Pec	08	2006	
	J, C		30. Name and address of person w					ent	Park	A) a	Carlla	bi's	mn	21044	
	Sta	ate	31. Date filed (Month, Day, Year)	32.	724 L	nature	A -a		741 00	ny	COININ	· · · · · · · · · · · · · · · · · · ·	1	-10//	_
	Regist		DEC 12	2006	20	15 /5	0844								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Concept of the property of t				For State Registrar	State of Ivia	-	<i>Certifica</i>				grene Reg. No≎ ∩ ∩ ⊂	20512
## An Part of the Control of Section of December   Section of Dece		Dhysisis			)							3. Time of Death
Common Superplane   Comm	Jr						1		and a company	Decemb		
2 County (Fourth Plantier College Character Principle College Character Principle Char	) *	Examin	er					, , , ,	ocation of Death			
Director    Director	-	Euneral				(In yrs. last bir	thday) If Und	er 1 Year   I		8. Date of Bird		rthplace (State or Foreign
10. Special and Number   10. Coling   10. Co	-500 to a	1		204-03-2093	]M 2⊠F	92	Yrs. Month	s Days	Hours Min.	Nov. 2	7, 1914 °	
Prival Care		and				10c. City, Town	n or Location					10d. Inside City Limits
Prival Care		Maryla f sho	lor		·e	Towso	n					1 □Yes 2 No
Prival Care		r 28a-	irec					ip Code			10g. Citizen of What C	ountry?
Prival Care		th with	al D	7718 Greenview Ter	r. Apt. 1	30						
Prival Canal Prival Canal Prival Canal C		ter dea	Fune		Armed Forces? 1 ☐ Yes 2 🔀 N					ecify Yes or No Rican, etc.)	14. Race - Am Black, Whi	ite, etc.
Prival Care	939	ours at	þ		If Yes, Give Year or Dates:		1 ∐ Yes	21XNo	Specify:		Specify:	wnite
Prival Care	2-0	"natu	letec	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a.	Decedent's Us (Give kind of v	sual Occupation of the country of th	on ring most of worki	ing	16b. Kind of Business	s/Industry
Prival Care	72	withir iene. than	dwo	Elementary/Secondary (0-12)							Welfare Se	ervices
Prival Care	פַ	e filed al Hyg other	3e C	17. Father's Name (First, Middle, Last)				1:	8. Mother's Name	e (First, Middle	, Maiden Surname)	
Prival Care	ylar	Menta	To E									
Physician (Medical Examiner)  Per page 19 (19 (19 (19 (19 (19 (19 (19 (19 (19	Jan	12 sho			, ,			,				Zip Code)
Physician (Medical Examiner)  Per page 19 (19 (19 (19 (19 (19 (19 (19 (19 (19	ق	t Healt Healt Item 2		20a. Method of Disposition								r Town, State
Physician (Medical Examiner)  Per page 19 (19 (19 (19 (19 (19 (19 (19 (19 (19	<u>m</u>	Page: ment o ant: If I ury or		4 □ Donation 5 □ Other (Specify,	12/1							
Physician / Medical Examiner  The past 2 points of	Balt	permit. Depart Import any In		21. Signature of Funeral Service Licens								
Physician (Medical Examiner)    Application   Figure   Fi				23a. art1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ne cause on each lin		not enter the m	ode of dying,	such as cardiac	or respiratory a		Interval Between
Sequentially list conditions, farly, leading to immediate Cause (Disease or injury that plant listed events resulting in death) Last replacement of the plant of				disease or condition	a. Aoren			515	Critic	الما		mouths
The part of the pa				Sequentially list conditions	b	2 concoquence	J.,.					
The part of the pa	L R	ed sit	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	of):					
Section   Sect	Ć,	execut in and ial-trar	Exan	that initiated events resulting in death) Last	c Due to (or as	a consequence	of):					
See Seption 10 10 10 10 10 10 10 10 10 10 10 10 10	876(	ate be hysicia the bur	lical	(	d							
24a. Was an autopsy performed?  25. Was case referred to medical examiner?  1 yes 2 No  25. Was case referred to medical examiner?  26. Place of Death (Check only onle)  27. Manper of Death  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury at Work?  29. Date of Death  29. Certifier (Check only onle)  29. Certifi					23c. If ves. outcome	of pregnancy					23d Date of de	elivery
24a. Was an autopsy performed?  25. Was case referred to medical examiner?  1 yes 2 No  25. Was case referred to medical examiner?  26. Place of Death (Check only onle)  27. Manper of Death  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury at Work?  29. Date of Death  29. Certifier (Check only onle)  29. Certifi		death death death death	ician	in the past 12 months?	1□Live birth 4□Pregnant at	2 Fetal death						,
24a. Was an autopsy performed?  25. Was case referred to medical examiner?  1 yes 2 No  25. Was case referred to medical examiner?  26. Place of Death (Check only onle)  27. Manper of Death  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury at Work?  29. Date of Death  29. Certifier (Check only onle)  29. Certifi	P.0	at the I by the stache	phys	9 ∐ Unknown					in Dord I	220 Did	tahanaa uga aantrihuta	to the course of death?
Section   Sect		luires the signed and be do	d by	Part II. Other significant conditions co	entributing to death bu	at not resulting i	in the underlying	g cause given	mranti.			~
25. Was case referred to medical examiner?  1	ecol	S S	plete							auto	psy prior to	
So Was case referred to medical examiner?    Continue of the property of the p	<u>~</u>	The cate had page	Com								ormed? death?	
27. Manner of Death   Natural   S   Pending   Investigation	Vit.	siclan certifi rector	Be	examiner?	Hospital:			Othor			- 4	HOSPICE
1   Natural   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   5   State   5   Pending investigation   5   Pending investigation   6   Could not be determined   28e. Place of injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifier   14   Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   29b. Signature and difference   29c. License number   29d. Date signed (Month, Day, Year)   29d. Date signed (Month, Day,	ō	g Phys er this eral dir	7: To	T Tes 25 No	28a. Date of Inju	ry 28b.	Time of	DOA	4 LI Nursing Ho			ecify) (1051 105
State    State	ion	ath. or: Aftu	ation	2 ☐ Accident investigation	(Month, Da)	7 1941)						
The state of the s	Divis	or Atterde after de Directo	rtific	- determined			arm, street, fact	ory, office				Rural Route Number,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1 per doc 9862 12-12-06 vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) BRUCE **ALAN** GINSBERG 2. Date of Death DECEMBER Day, 2006 Physician -BRUCE GINSBERG 9:33 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 04/22/1951 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 216-46-3353 55 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medica Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD BALTIMORE PHOENIX 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2500 CARROLL MILL ROAD 21131 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify WHITE þ 3 ☐ Widowed 4 🛱 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PLUMBER PLUMBING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM GINSBERG LENORE 2 SCHIMBERG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3408 DEEP WILLOW AVENUE - BALTIMORE, MD 21208 LENORE GINSBERG / MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP 4 □ Donation 5 □ Other (Specify) 12/08/2006 TOWSON, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Hah 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ear. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient pice 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Vecember 7, 2006 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

6701

gistrar's Signature

Balto Md 21208

Death

Year

29d. Date signed (Month, Day, Year)

December 11, 2006

To the Hospital or Attending Physician: To the

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

2006

29b. Signature and title of certifie

Tasha Greenberg MD.

for

31. Date filed (Month, Day

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Jerome Somes Hewisler Please Type or Print in Black Indelible Ink 06-08631 UNK UNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day November 13, 2006 Medical Examine 0317 hrs Jerome James Heuisler 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 849 Wellington Street Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Months Days Hours Min Foreian Director Country) MD 219-62-1287 1 X M 2 F 50 SEP 29. 1956 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits Yes 2 No 28a-f show s 23a or 28a-f show e notified at once. MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 849 Wellington Street 21211 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces' White, etc. Yes 3 Widowed 4 Divorced If Yes, Give Year Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hours after
Department of Health and Mental Hygione.
Important: If lien 27 is marked other than "natural"...
Injury or other traumatic event, the Medical Examined. 1 Yes 2 X No specify: Specify: White ò 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Landscaper 10 Landscaping 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Joseph Heuisler Lillian Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian W. Heuisler, mother 2802 Miles Avenue Baltimore, MD21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State crematory or other place) Metro 12/12/06 Donation 5 Other Specify Crematory Baltimore, 21 Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 23a. Part I. Enter the disease, or 6 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Alcohol and Narcotic Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical physician the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Hypertensive cardiovascular disease Completed 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other<sub>4</sub> ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 28a. Date of Injury (Month. Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural found at Pending Yes 2XX No within 24 hours after death. To the Funeral Director: UNKNOWN the Found on Investigation Accident nome, arm, sireet, factory, office building, etc. 28e. Place I Injury A 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide (Specify) FOUND IN DWELLING 849 WELLINGTON ST., BALTO., MD Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. **Medical** (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) OCME November 13, 2006

OCME 2006

State Registrar nd address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

egistrar's Signature

111 Penn Street, Baltimore, MD 21201

Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year)

		1	For State Registrar		State of	of Maryla			ment of F iicate of			/lental F	lygien Reg. N		39	5	
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	er dea Items ner m	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 1	<ol> <li>Was Decedent E Armed Forces?</li> <li>1 ☐ Yes 2XXIII</li> </ol>		13. Was If Ye	Decedent of Hi s, specify Cuba	spanic Origin, Mexican	gin? (Specify ` ı, Puerto Ricar	Yes or No- n, etc.)	14. Race - An Black, Wi	nerican Indian, nite, etc.
38	urs aft al', or xami	þ	3 X Vidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗆	Yes <b>XX</b> No	Specify:			Specify: W	nite
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Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service License	e		22. Na	ame and Addres	ss of Facilit	ty			
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Вох	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome p 1 ☐ Live birth			topic pregnancy	/			23d. Date of o	delivery Day Year
0	he dea the at	Physician/Me	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death	5∐ Ot	ther (specify)					
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eco	law requas been 2 should	Completed								24a. Was ar autopsy	y prior	autopsy findings available to completion of cause of
E E		Соп								perform 1 Yes 2	ned2 death PNo 1 □ Y	
ΖÏ	sician certifi rector	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ ₩o	lospital: 1	nt 2∏ER/Out	nationt	3□ DOA Oth		of Death (Ch		e) nce 6 □Other (S	pacifu)
o l	ding Physician: The I h. After this certificate ha funeral director, page	n: 7	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. T		28c. Injur Wor				w injury occurred	респу
sior	endin sath. or: Aft he fun	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation				M 1□	Yes 2□				
Division or Vital Records,	l or Attending Physician: after death. Director: After this certifica I in by the funeral director, I	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju building, etc	iry - At home, far c. (Specify)	m, street,	, factory, office		28f. I	Location (Str City or Town	reet and Number or , State)	Rural Route Number,
Ц	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer.		29a. Certifier 1 Certifying Phys	ician: To the best o	of my knowledge	, death or	ccurred at the ti	me, date ar	nd place, and	due to the ca	ause(s) and manner	as stated.
	the Hospital hin 24 hours a the Funeral upletely filled	Medical	(Check only 2 Medical Examination one)	ner: On the basis of and manner sta		d/or inves			ath occurred a			
	To t To t	Σ	29b. Signature and title of certifier		MAS.		29c. Licens	e number	U	29	9d. Date signed (Mo	onth, Day, Year)
F	1		- Louve		MY (Itam 33a) (						, , (	
	P		30. Name and address of person who co	MI. 821	N. EVT	MIN	St Bruk	te 30	& BA	timo	REMI) 2	21201
		ate	31. Date filed (Month, Day, Year) DEC 1 2 2006	32. Registra	ar's Signature	2600						
	Regist	rar	DEO T S COOL	AST DESCRIPTION OF	and the same	-						

06-09218 Patricia Holmes Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Month Day December 4, 2006 Medical Examiner Patricia Louise Holmes 0914 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore n/a 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 9. Birthplace (State or **Funeral** Foreign Maryland Months Days Hours Director 1 M 2 x F 04/17/1951 217-52-9573 55 Usual Residence of Decedent any 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Yes 2 No 28a-f show Baltimore 23a or 28a-f sho notified at once, MD n/a death with the Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code  $\bar{\Box}$ 2902 Kingsley Street 21223 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be or items Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Yes 2 X No Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White Examiner "natural", þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) 2 should be filed within 72 hon and Mental Hygiene
27 is marked other than "no Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical MD 21215-0036 7 Stocker Retail 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Charles Richard Smith Lorraine Katherine Roles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 should ment of Health and M rant: If item 27 is m Larry G. Holmes, Jr. 3563 Wilkens Ave Baltimore, MD 21229 / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c Location - City or Town, State Baltimore, rtant: If it crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/09/2006 Sykesville, Maryland important; Crestlawn 4 Ponation 5 Other Specify: 22. Name and Address of Facility 21. Si r ature of Funera ervice Licer Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd Lansdowne. MD Part I. Enter the disease, or Physician failure. List only one cause on each line. Between Onset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) eause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and sician/Medical tending physician a use as the burial -X UNPENDED AMENDED #23a.27.permE. g863, 1/2/07 TT P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 ✓ Yes 2 No To the Hospital or Attending Physician: 25 Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> this DOA Nursing Home 5 Residence 6 Other: 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) After Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No 5 Pending Director: Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) Funeral (Specify) Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. December 5, 2006 Name and address of person who dompleted cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD. 31. Date filed (Month, Day, Year) Registrar's Signature State 2006 Registrar

			For State Registrar	State of Ma	aryland / Depa	artment of H			giene 006	39520
	01		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day Year	3. Time of Death
	Physici /Medic			CATHERI	NE R.	HOWELL		DEC.	9, 2006	11:20 P
	Examin		4a. Facility Name (If not institution, give s CARROLL LUTHERA		GE	4b. City, Town, or WESTMI		1	4c. County of Dea	
	Funeral Director		215-18-7741	м 2X F 7. Age	a (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 6 / 1 9 /		rthplace (State or Foreign ountry)
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. fnside City Limits
	Mary Ind	ţō	MD CARROLI		WE	STMINSTE	R			1. Yes 2 □ No
	or 28s	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	ath wi	rai	205 ST. MARK W.			2115			USA	
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 le marked other then "natural", or Iteme 23a or 28a-f ehow important: If Item 27 le marked other then "natural", or Iteme 23a or 28a-f ehow any Injury or other traumatic event, the Madical Examinar must be notified at ADCs.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent If Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Sponsories, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.
20	72 ho	eted	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Occupa kind of work done d	ition uring most of wor	kina	16b. Kind of Business	s/Industry
21215-0036	d within giene. Fr then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retired; INSPECT			MANUFAC	TURING
	be file ital Hy id othi	Be	17. Father's Name (First, Middle, Last)		TOUTC D				Maiden Sumame)	NMC
Maryland	should nd Men marke	ဥ	19a. Informant's Name/Relationship (Ty		LOUIS F				LA WILLIA	
Ma	th and the result of the resul		CHARLES I. FRIC			FALCON D			MD 211	· '
Je,	s 1 ar	-	20a. Method of Disposition		20b. Place of Disp			Date	20c. Location - City o	r Town, State
Ē	Page nent c ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State I	DEER PARI	•		3/06	SMALLWOOD	, MD
Baltimore,	permit. Departr Importe eny Inje		21. Signature of Eune al Service Licens	90					FUNERAL MINSTER,	HOME, P.A. MD 21157
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused to cause on each lin	the death. Do not a	ter the mode of dying	, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Me	tack	Tec C	ano	or		Onset and Death
1	/Medical Examiner		resoluting in socially	ue to (or as	a consequence of):					
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of.					
	sicien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
760,	be executed icien and burial-transit	EX	resulting in death) Last	Due to (or as	a consequence of):					
6876	= > =	dical		l						
9 x	certifi ding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome					23d. Date of de	afivery
.O. Box	The law requires that the death certifical tite has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	in the past 12 months?  1  Yes 2 No 9  Unknown	1 □ Live birth 4 □ Pregnant at 9 □ Unknown		□Ectopic pregnancy □ Other (specify)			Month	Day Year
S, P	w requires that s been signed E should be deta	by P	Part II. Other significant conditions con	tributing to death b	ut not resulting in the u	inderlying cause give	n in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Records,	equire sen sig	ted						101	'es 2 □ No 3 □ P	robably 4 Unknown
ec	alaw ( has be e 2 sh	Completed						24a. Was autop	sy prior to	utopsy findings available completion of cause of
a H								perfor	med death? No 1 □ Ye	s 20 No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	lospital:	int 2 ☐ ER/Outpatie	ot all DOA Othe		th Check only o	ne) lence 6 □Other (Sp	antd.
of	g Phys er this eral di	n; To	27. Manner of D. ath	28a. Date of Inju (Month, Da	ry 28b. Time o				now infury occurred	<del>э</del> спу)
Ö	Attending I death. ctor; After y the funer	atio	1 Natural 5 Pending investigation	(World, Da)	y rear / Inquity		res 2□No			
Division	tel or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of fnet building, etc	ury - At home, farm, st c. (Specify)	reet, factory, office	234/1922	28f. Location (5 City or Tou	Street and Number or F m, State)	Rural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director, After this certific completely filled in by the funeral director.	Medical			examination and/or in				cause(s) and manner a date and place, and du	
	To the comp	Σ	29b. Signature and title of certifier	2		29c. License	number		29d. Date signed (Mon	oth, Day, Year)
<b>)</b>			Heurte	D.D.		HER	558	43	12/11/2	06 300
	6		30. Name and address of person who ex	mpfeted cause of d	eath (Item 23a) (Type	Print) Property	and i	Q. 5	Bull.	7-1516
	Str	ate	31. Date filed (Month, Day, Year)	324Registra	ar's Signature	1 July	war v	-ag a	carrie	J' W.
	Regist		DEC 1 2 200	6 Roman	M. An	and I				
DH	MH 17 Rev 1/2	2001		2						

			State of Maryland / Department of Health and N  State  State  Certificate of Death		<b>1</b> 2006	39521
4	Physicia	an	Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	12	7 06 4c. County of Death	1200 7111
	EXAMININ	ei	GOOD SAMARITAN HOSPITAL BALTIMORE		NIA	
*	Funeral Director	4	5. Social Security Number 6. Sex 1 M 2 A F 7. Age (In yrs. last birthday) 11 M 2 A F 7. Age (In yrs. last birthday) 12 Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Cou	place (State or Foreign ntry)
	yland		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Ba-f st	ctor	Md. NIA BALTSMOKE			1 XYes 2 No
	with th	Funeral Director	10e. Street and Number 10f. Zip Code 2/206	10g.	Citizen of What Cou	•
	me 23	neral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri	can Indian,
2LDER 21215-0036	within 72 hours after deeth with the Maryland jiene. r than "natural", or iteme 23a or 28a-f show the Medical Examinar must be notified at	by	Armed Forces?  1 Never Married 2 Married  1 Yes, Specify Cuban, Mexican, Puerto  1 Yes, Give  Year or Dates:	rican, etc.)	Black, White,	ac.
5-0 5-0	"natur	letec	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work ille, DO NOT use retired)  iife, DO NOT use retired)	ang 16t	. Kind of Business/Ir	dustry
40LDE		Completed	Elementary/Secondary (0-12)  College (1-4or 5+)  N/A  ASSEMBLY  LINE  OPE	ERATOR M	d. Cop	60.
	be filed tal Hyg d othe	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle, Mail	den Sumame)	
A Ha	ges 1 and 2 should be t of Health and Mental if item 27 is marked or or other treumatic ev	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run	al Route Number, C	ity or Town, State, Zi	
Z -	s 1 and if Health item 27 other tr		20a Method of Disposition 20b. Place of Disposition (Name of		c. Location - City or T	
ZELA	Pages ment of ant: if it		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	3/06 7	undask.	Md.
Barri	permit. Page Depertment of Important: If any Injury or		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 24	1	ROMPETION Md. 8	
58760,	ocia se	edical Examiner	23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  CLUDICARDITIS & IFFIC CARDITIS due to (or as a consequence of):  d.		ITES	Approximate Interval Between Onset and Death
.O. Box 68	that the death certificate I ed by the attending physi detached for use as the t	Completed by Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   Yeo   9   Unknown   2   Cho   9   Unknown   3   Ectopic pregnancy   5   Other (specify)   9   Unknown   5   Other (specify)		23d. Date of deliv Month	ery Day Year
rds, P	w requires that s been signed b should be deta	ed by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  ESRD on Hemodyslysis, HTW,		co use contribute to t	
Division of Vital Records, P.O.	The law re ate has bee page 2 sho	Complet	ATRIAL FIBRILLATION, DYSLIPIDEMIA	24a. Was an autopsy performed 1 ☐ Yes	prior to co death?	opsy findings available impletion of cause of
Vita	icien: Th certificate rector, pag	Be	examiner?	th Check only one)		
on of	ling Phys	lon: To	27. Manner of Death  Natural 5 Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  28c. Injury at Work?	ome 5 Residence 28d. Describe how	e 6 Other (Speci injury occurred	fy)
Divisio	or Attencater death Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined elemined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	t and Number or Rur itate)	al Route Number,
	Hospite 4 hours Funerei ely filled	edical Ce	29a. Certifier (Check only one)  Check only one)  (Check only one)  (Check only one)  (Check only one)	and due to the caus red at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier  **Naled Catela M.D.** RES 000	29d.	Date signed (Month, 2 / 7 / 06	Day, Year)
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  5601 LOCH RAVEN BLVD, BALTIMORE, MD, 2.	1279		
	Sta	te	5601 LOCH RAVEN BLVD, BALTIMORE, MD, 2. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	1251		
	Registr	_	DEC 1 2 2006 Present A Company			

			1 - For State Registrar		Maryland / Dep		of Healt	th and M	lental Hygi		006	39522
	Physici	20	1. Decedent's Name (First, Middle,	Last)					2. Date of Death	Day	Year	3. Time of Death
	/Medic		LILLIE U. HILI						DECEMBER	6,	2006	7:15p M
1-	Examir	er	4a. Facility Name (If not institution, 11322 WINDSOR		er)		own, <i>o</i> r Locat ISVILLE				unty of Death REDERI	CK
	-				Age (in yrs. last birthda			nder 24 Hrs.	8. Date of Birth			
	Funeral Director		181-44-2957	1□M 21/2 F	94 Yrs.		Days Hou	urs Min.	8. Date of Birth (Month, Day, 9-6-191			place (State or Foreign ntry) GINTA
	ש		Usual Residence of Decedent						9-0-191			
	aryter ehow	_	10a. State 10b. County	T CIZ	10c. City, Town or							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	he M	Funeral Director	MD • FREDER	CICK	IJAMSV		2-4-1		10	- 02		
	with	급				10f. Zip (					of What Cou	ntry !
	ns 23	era	11322 WINDSOR  11. Marital Status	12. Was Decede	ent Ever in U.S. 13		1754 ent of Hispanio	c Origin? (Sp	ecify Yes or No-		SA Race - Ameri	can Indian,
9	after o	F	1 Never Married 2 Marrie	Armed Force	es?	If Yes, specif			ecify Yes or No- Rican, etc.)		Black, White,	etc.
21215-0036	d within 72 hours after death with the Marylend Jone. r than "natural", or items 23a or 28a-f ehow the Mazikal Examinar must be notilled at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Date		1 ∐ Yes 2	P No Spe	эсіту:		Spi	ecify: BL	ACK
5	natu	Completed	15. Decedent' (Specify only highest	s Education grade completed)	(Giv	edent's Usual e kind of work	done during	most of work	ing 1	6b. Kind a	of Business/In	dustry
121	within ene. than "	dmo	Elementary/Secondary (0-12)	College (1-4d	or 5+)	DO NOT use DUSEWIF				НО	MECARE	
	tle Thys	Be Co	17. Father's Name (First, Middle, L	ast)			18. M	Nother's Name	e (First, Middle, M			
lan		To B	CHARLES B. JAC	KSON				JOSEPH	IINE FORE	MAN		
Maryland	d 2 should th and Mer ?7 is marke traumatic		19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Ma	ling Address (	Street and Nu	umber or Rura	al Route Number,	City or To	wn, State, Zip	Code)
_	s 1 and 3 Health item 27 other tr		LILLIE BASKERV	ILLE (DAUGH	The second second second second				MSVILLE,			
Baltimore	Pages 1 nent of H int: if ite		20a. Method of Disposition 1 X Burial 2 Cremation	3 ⊋Removal from Sta	20b. Place of Dis cemetery, cr	oosition (Name ematory or oth	e of ner place)		Date 2	0c. Locati	ion - City or T	own, State
Ë	rtmen ortant: njury		4 Donation 5 Other Sp	ecfty)	WEST NEW	ON CEM	ETERY	12-14	-2006 W	EST	NEWTON	PENNA.
Ba	Depril		21. Signature of Juneral Service L	JONATH	AN D. HIBNI				OR H. WI			ERAL HOME,
			23a. Part . Enter the disease, or of sheck or heart failure. List of	complications that cause on each	sed the death. Do not e						171	Approximate Interval Between
л	Physician		Immediate Cause (Final disease or condition	Aco	to REN	A/ Z	Ailu	10				Onset and Death
	/Medical		resulting in death)	a. Due to (or	as a consequence of);	. //	11 )					WKS
*	Examiner	L	Sequentially list conditions,	b. Atr	IAI Fib	1/1/2	HOW					wks
,_	bed isrt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of):	Hom	mba	cie				24.20
	axecul and al-trar	xan	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):	VIIOI	1100	1/1				mos
160	ate be executed hysicien and he burial-transit	cai		d Dem	nentia							45
9	tificat ng phy as th											
Вох	death certifica e ettending ph id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		□Ectopic pred	gnancy			23d.	Date of delive	
	e dea the et ned fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		t at time of death 5	Other (spec					Month	Day Year
P.0	requires that the de reen signed by the e hould be detached f	Phy	Part II. Other significant condition	1 contribution to deat	hut not resulting in the	underlying ca	uso guyon in P	lart I	23a Did taba	acco uso	anatahuta ta t	he cause of death?
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Re	a 2 2	Completed	ix fees all	L'and	etlog 41.	CHIC			24a. Was an autopsy perform	1	prior to co death?	ppsy findings available impletion of cause of
		C	25. Was case referred to medical	15 Unak	exia, os	tope	20515	N 4 D	1 ☐ Yes 2	<b>⊠</b> No	1 🗆 Yes	2 No
of Vital	Physician: r this certific ral director, i	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 □ Inp	atient 2 ER/Outpati	ent 3 DOA			n (Check only one		Other (Specif	Hospice
סר	두 드 교		27. Manner of Death	28a. Date of I		of 286	c. Injury at Work?		28d. Describe how	v injury oc	curred	"Flos pice
<u>S</u>	Attending r death. ector: After by the fune	atic	1 KNatural 5 Pending 2 Accident investigs	ation	-a, , , , , , , , , , , , , , , , ,	м	1 Yes 2	2 □ No				
Division	br Att	Certification;	3 Suicide 6 Could no 4 Homicide determin	286. Place of	Injury - At home, farm, setc. (Specify)	treet, factory,	office		28f. Location (Stre City or Town,		umber or Rura	al Route Number,
	pitel ours at prei Distriction		20a Cadilian 4FI Cadibilia	Dhariston T.								
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edicai	29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Medical E	xaminer: On the basis and manner	st of my knowledge, dea s of examination and/or stated.	nvestigation, i	i ine time, date n my opinion,	e and place, death occurr	and due to the cau ed at the time, dat	ise(s) and e and pla	manner as s ce, and due to	tated. o the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	0:11	, in in	29c.	License numb	ber 7 / /			gned (Month,	
)			· allen /	telle	1 1110	6	154	414	7 /	2	07	2006
	10		30. Name and address of person w	· · · · ·	of death (Item 23a) (Type	Print)	ve D-	1 FR	EDERIC	K.A	40 71	701
1	Sta		31. Date filed (Month, Day, Year)	32 Regi	strar's Signature	F1		.,.,.		-/-	Ken !	
4	Registr	ar	DEC 1 2	2006	K A	and a						
DH	MH 17 Rev 1/2	001		1	All	Transfer of						-

			For State	State	of Marylar		artment of H			20	06	39523
	4		Registrar  1. Decedent's Name (First, Middle	l act)		Cel	lineale of L	Jeani ————————————————————————————————————	2. Date of Death	. No.C U	00	3. Time of Death
П	Physicia	an	Λ .	ne.	14	obbs			Month DECEMBE	Day	Year	11:30a
of the same	/Medic		4a. Facility Name (If not institution				4b. City, Town, or	Location of Death		4c. County	006 of Death	11:30a
	Examin	er	124 KEYWORTH				BALTIMO	ORE		N/		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			lace (State or Foreign
ь	Director		218-60-6884	1 □ M 2/□ F	55	Yrs.	Months Days	Tiodis Willi.	1-28-1			LAND
	pu >		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ity, Town or Lo	cation				1	0d. Inside City Limits
	laryla sho ed at	ō	MD. N/A			BALTIMO						1∭Yes 2□No
	the N 28a-1 notifi	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of	What Coun	try?
	3a or st be		124 KEYWORTH	ST APT	204		21215			USA		
	death ms 2 r.mus	Funeral	11. Marital Status	12. Was D	ecedent Ever in U	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	pecify Yes or No-		ce - Americ	
ဖွ	after or ite mine		1 XNever Married 2 ☐ Marr		s 2 TNo		1 □ Yes 2 ∏ No	Specify:	o i noun, oto.,		y: BLAC	
5-0036	ural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year o	r Dates:				4.			
2	"nati	Completed	15. Deceden (Specify only highe	st grade complete		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	iurina most of wor	king	5b. Kind of B	usiness/inc	lustry
2121	within iene. than the M	dwg	Elementary/Secondary (0-12) -12-	-	e (1-4or 5+) 2 <b>–</b>		ERICAL	·		LEGA	L AII	Œ
0	Hygie other ent, tt	Be C	17. Father's Name (First, Middle,		-			18. Mother's Nam	ne (First, Middle, Ma			
<u>la</u> u	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. In marked other than "natural", or items 23a or 28a-f show in martic event, the Medical Examiner must be notified at	To B										
Maryland	ges 1 and 2 should it of Health and Men If item 27 Is marke or other traumatic		19a. Informant's Name/Relations			1	ng Address (Street a		,			Code)
	and and n 27		VAILE LEONARI	)(FRIEND			3 KYLE CT	• BALTIMO				
altimore,	Pages 1 nent of H int: If iter		20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation	3 Removal fro		cemetery, cre	osition (Name of matory or other place	i i		Oc. Location	·	
Ē	t. Pa rtmen rtant: njury	- 01	4 Donation Other €				ORIAL PAR					IARYLAND
Ba	permit. Pag Department Important: I any injury o		21. Signatur Himelal Service	Licensed ONA	Alis		2. Name and Addres					AND 21217
4	. 4)		23a. Part1. Enter the disease, or shock of heart failure. List	complications the	at caused the dea						TIMELL	Approximate Interval Between
-02	Physician		Immediate Cause (Final	only one cause o	on each line.	0 0	Myocaso	1 - 1 -	Whom	HOH		Onset and Death
1	/Medical		disease or condition resulting in death)	a	to (or as a conse	quence of):	Jocqui	1	1			
	Examiner		Conventially list conditions	b	Athe	words	erotic	NearT	dis	ease	_	
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	to (or as a conse	quence of):	**					
V	recute and I-trans	Examiner	that initiated events resulting in death) Last	c. Due	to isses a conse	quence of):	Μ.				_	
8760,⊲	The law requires that the death certificate be executed the has been signed by the attending physician and order 2 should be detached for use as the burial-transitions.	ical E			Mesca	1						
687	ficate physis the			a.								
Box	death certifica attending phase as t	n/M	IF FEMALE: 23b. Was decedent pregnant		outcome pf pregr ve birth 2 □ Fet		⊒Ect <i>o</i> pic pregnancy			23d. Da	ate of delive	ery
	death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pr	egnant at time of		Other (specify)			Me	onth	Day Year
<u>Р</u>	at the by th	hys	9 ☐ Unknown	ļ					00 - Pida-b			
	ires that the de signed by the a d be detached t	þ	Part II. Other significant conditi	ons contributing to	o death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did toba	~	tribute to tr 3 □ Prob	ne cause of death? ably 4 □Unknown
orc	w requir	ted	214000	-10							161 SK192	
Jec	e law has	Completed	DAZIBIO	demia					24a. Was an autopsy perform	- 1	Were auto prior to con death?	psy findings available npletion of cause of
a	ician: T certificate rector, pag		05 W						1  Yes 2	No	1 ☐ Yes	2 No
₹	Physician: r this certifica ral director, I	) Be	25. Was case referred to medica examiner?	Hospital:	□Inpatient 2	☐ ER/Outpatie	ot 3 DOA Othe		ath <i>(Check only orle</i> Iome 5 Resider		nor (Cnaoit	
0	y Physer this eral dil	1: To	27. Manner of Peath	28a. Da	ate of Injury	28b. Time o			28d. Describe how			//
ion	Attending F r death. ector: After by the funer	atio	1 Natural 5 Pendir 2 Accident investi	19 1 '	Month, Day Year)	Injury		Yes 2 □ No				
Division or Vital Records,	r Attend er death rector:	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	sined Zoe. Fl	ace of injury - At I	nome, farm, st	reet, factory, office		28f. Location (Stre City or Town,		ber or Rura	I Route Number,
Ö	ital o											
	To the Hospital or Attending Physician: T e I within 24 hours after death.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical	29a. Certifier  (Check only one)  Certifying  Medical	Examiner: On the	the best <i>o</i> f my kr ne basis of examir nanner stated.	iowledge, deal nation and/or ir	th occurred at the tin evestigation, in my o	ne, date and place pinion, death occi	e, and due to the ca urred at the time, da	use(s) and m te and place	anner as s , and due to	tated. the cause(s)
	To the within 2 To the Comple	Mec	29b. Signature and title of certific		namer stated.		29c. License	e number	29	d. Date signe	ed (Month,	Day, Year)
	⊢ ≤ ⊢ ŏ		VITI	NON	OU M	$\mathcal{D}$ .	DO	0062P	14	12/11	06	
	1		30. Name and address of person				Print)	10/00	6 #40	9 R	altiv	nore,
-	1		Chintan	Des		301 5	57. Val	O A MC	1	M	D 2	1202
	Sta		31. Date filed (Month, Day, Year,		2 Registrar's Sigr	nature	ali					
	Regist	ar	DEC T	2 2.000		~ 54						

06-09268 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Monique Ireland 1- For State Certificate of Death Registrar Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day December 5, 2006 1351 hrs Medical Examiner ve 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (if not institution, give street and number N/A **Baltimore** Sinai Hospital 7. Age (In yrs. last birthdav) If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Foreign Country) Hours Director 35 yarch 3.197 2 1 M Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 1 Ves 2 No Baltimore N/A or 28a-f show items 23a or 28a-f showust be notified at once. MD death with the Maryland Director 10g Citizen of What Country' 10e. Street and Number 21215 USA 4103 Ridgewood Funeral 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Mantal Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 4 Frican Yes 0. 1 Yes 2 No specify If Yes, Give Year the Medical Examiner marked other than "natural", ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: I fiem 27 is marked other than mijury or other tranmarit event, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) Haindresser 124 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Ethel Parker Michael Garrett, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ridgewood Avenue Ballymone MO 21215 Ethel Parked mother 20b. Place of Disposition (Name of cemetery, 2 Cremation 3 Removal from State crematory or other place) 12-11-06 Baltmone, Mo Sayview Cremathy 4 Donation 5 Other Specify 22. Name and Address of citity nemal Sewice P.A.
Han P. Close Funeral Sewice P.A.
5126 Belain Road, Bathmone mD 21206-5185
5126 Belain Road, Bathmone MAD 21206-5185
Approximate Interval 21. Signature of F the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and failure. List only one cause on each line /Medical Death Bilateral pulmonary thromboemboli Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Deep venous thrombosis of the leg Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical X UNPENDED ing physician a #23a-b.PII.27.perME, g862, 12/16/06 TT Division of Vital Records, P.O. Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions ģ No 3 Probably 4 V Unknown Yes 2 Cocaine use Completed 24b. Were autopsy findings available 24a Wasan prior to completion of cause of autopsy death? performed? ✔ Yes 2 1 🗸 Yes After this certificate 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 / Inpatient 2 Other<sub>4</sub> DOA Nursing Home 5 Residence 6 ER/Outpatient 3 1 Yes 2 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death Certification: 1 X Natural 1 Yes 2 No Director: Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) determined (Specify) Homicide

within 24 hours at To the Funeral L completely filled

Tasha Greenberg MD. 31. Date filed (Month, Day, Year) DEC 1 2 2006 State Registra

DHMH 17 Rev 1/2001

OCME 2006

29a Certifier 1

Vasher

2. Registrar's Signature

and manner stated

Assistant Medical Examiner

ell

30. Name and address of person who completed use of death (Item 23a)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

December 6, 2006

06-09292	
Carol lear	

Carol Iser	State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death  Reg. No. 2005 39525
Physician/	1. Decedent's Name (First, Middle,Last)  2. Date of Death Month Day Year Month Day Year
Medical Examiner	CAROL LYNN ISER December 6, 2006 0927 fts  4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Carroll Hospital Center Westminister Carroll
Funeral Director	5. Social Security Number 220-13-4134  7. Age (In yrs. last birthday) 1 M 2 X F  3 2 Yrs.  1 Months Days Hours Min.  3 4 / 0 1 / 1 9 7 4  1 M 2 X F  3 2 Yrs.  3 2 Yrs.  3 2 Yrs.  3 3 2 Yrs.  3 3 2 Yrs.  3 3 2 Yrs.  3 3 2 Yrs.
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
<b>*</b>	MD CARROLL WESTMINSTER 1 Yes 2 K No
Di fiffe	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4005 LITTLESTOWN PIKE 21158 USA
r death with , or items 23 r must be no Funeral	11. Mantal Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc.
s after de ral", or niner mu by Fu	1 Yes 2 X No 3 Widowed 4 Divorced If Yes (Sive Year or Dates:  1 Yes 2 X No specify: Specify: WHITE
hours a	45 December 15 January 16 - and to published example and appropriately 160 December
11215-0036 Id be filed within 72 hours af dental Hygiene narked other than "natural event, the Medical Examin o Be Completed by	College (1-4 or 5+)   College (1-4 or 5+)   HOUSEWIFE   HOME MAKER
21215-0036 Juld be filed within 7 Mornal Hygiene marked other than c event, the Medica FO Be Complé	17. Talifer 5 Marine (1 not, middle) 2007
2121 ould be fill d Mental Ess marked tite event, To Be	JAMES E. RICHARDS MAY LOUISE LOWE  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD 2 shou eath and 2 shou tem 27 is n traumatic	MICHAEL P. ISER - HUSBAND 4005 LITTLESTOWN PIKE, WESTMINSTER, MD 21158
nore, lages I and of Heal it: If item other tra	20a Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State
Baltimore, pemit Pages Lar Department of Hee Important: If ite injury or other tr	4 Donation 5 Other Specify: EVERGREEN MEM.GARDEN\$ 12/11/06 FINKSBURG, MD
Balt permit Depart Import	254 E. MAIN ST., WESTMINSTER, MD 21157
Physician	23a. 1 art I. Firer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure distingtions one cause on each line.  Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)    Fentanyl intoxication   Death
/ /	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
ed nsit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):
to,  te be executed ysician and burial - transit	d.
0, be execut sician and burial - tra	X UNPENDED #5, 23a,PII,27,28a-f, per ME, g863, 1/5/07 TT  IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery
). Box 68760 the death certificate by the attending phytiched for use as the broked for use as the Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   23d. Date of delivery   2
Sox (leath ce e attend for use vsici	4 Pregnant at time of death 5 Other (Specify) 9 Unknown
Division of Vital Records, tat or Attending Physician: The law require its after death all Director: After this certificate has been sighed in by the funeral director, page 2 should be artification: To Be Completed	autopsy prior to completion of cause of performed? death?
I Rectificate or, page	
Vital sysician this cert directo	examiner? 1 Ves 2 No  Hospital: 1 Inpatient 2 VER/Outpatient 3 DOA  Other4 Nursing Home 5 Residence 6 Other:
Ing Ph After t funeral	
ision Attence death rector: by the	1 Natural   5 Pending   Investigation   Accident   3 Suicide   6 X Could not be   6 X C
Division or spiral or Attending rours after death nerral Director: After filled in by the fune Certification:	3 Suicide 6 X Could not be determined Homicide (Specify) found at home or Town, State) 4005 Littlestown Pike Westminster, MD
Division of Vital Rec To the Hospital or Attending Physician: The L within 24 hours after death To the Funeral Director: After this certificate b completely filled in by the funeral director, page Medical Certification: To Be Com	
F 3 F 8	
	Patri arania - Ellar O.C.M.E. December 7, 2006
	30 Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registra	
DHMH 17 Rev 1/2001	

			For	State of Marylar		nt of Health and M	Mental Hygier	ne nns	39526
			1 - State Registrar		Certifica	ite of Death	Reg.	NZ UU6	
	Physici	an	1. Decedent's Name (First, Middle, Last,	Toh	inson		2. Date of Death	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)	-	y, Town, or Location of Death		266 200 kg 4c. County of Death	
1	LXamii	-	20 Seph F	Sickey 1-	USPICE	Ba Himo	re		) [H
	Funeral		5. Social Security Number 6. Sec	7 Age (In yrs.	Month	ler 1 Year If Under 24 Hrs. s Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	nplace (State or Foreign
	Director		Usual Residence of Decedent	86	Yrs.		5-25-1	920 5.	CAROLINIA
	yland		10a. State 10b. County	10c. Ci	ity, Town or Location				10d. Inside City Limits
	e-1-e-	ctor	IMD N	11+	5a	timore			1 Yes 2 No
	or 28	Director	10e. Street and Number	1	10f. 2	Zip Code	10g.	Citizen of What Cou	untry2
	eath v	erai	3114 EUS	12. Was Decedent Ever in U	IS 13 Was Day	C/CO	pacify Vac or No.	14. Race - Amer	ican Indian
(0	r Herr d	Fun	11. Marital Status  1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
21215-0036	within 72 hours after death with the Maryland ane. then 'naturel', or items 23a or 28a-i ehow he Madical Exeminer must be notified at	Completed by Funeral	3 ₩idowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify:	laci
5-0	"natu	etec	15. Decedent's Edu (Specify only highest grad		16a. Decedent's Us (Give kind of	vork done during most of worl		. Kind of Business/l	ndustry
12.	withir ene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	life. PO NOT	se wife		Domes	+10
	e filed Il Hygid other	0	17. Father's Name (First, Middle, Last)	1			e (First, Middle, Maid		
ylar	2 should be filed within and Mental Hygiene. Ie marked other then eumatic event, the Mental count, the Mental counts.	To B	Kutus S	HORT		Emm	a hit	te	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other then "naturel", or items 23a or 28a-f show or other treumatic event, the Madical Examinal must be notified at		19a. Informant's Name/Relationship (Ty	***	2001	ss (Street and Number or Ru	-		10.1
_	1 and 2 Health a iom 27 io		20a. Method of Disposition	1 10.00	Place of Disposition (A	ASTUDIO DI	Date, SalT	Location - City or T	Cown. State
Baltimore,	Pages nent of int: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, crematory o	other place)	16/06 5	WTH C	acolina
alti	글 투면금 .		21. Signature of Funeral Service Licens		22. Name	and Address of Pacility	well f	unene	Hone
ă	Depa impo eny ic		Monak 1	towell &	SR 4600	WBERTY 1	the Bi	00 MD	21207
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the dea ne cause on each line.	th. Do not enter the m	ode of dying, such as cardiac	or respiratory arrest.	0.424	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Metasta	tic rect	al carcinoi	na		Onset and Death
1	/Medical Examiner			Due to (or as a consec	quence of):				· Ofti
	الجهد	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):				
18	ocuted nd transil	Examiner	that initiated events	o. <u></u>					
8760,	The law requires that the death certificate be executed site has been signed by the attending physician and page 2 should be detached for use as the burial transit	EX	resulting in death) Last	Due to (or as a consec	quence of);				
687	icate physics the	edicai		j					
ŏ	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn	ancy			23d. Date of deliv	very
.B	ne deatl the atte	sicia	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown				Month	Day Year
P.O.	that the dead by the detached	Phy	9 ☐ Unknown  Part II. Other significant conditions con		sulting in the wederhies	record awar in Deat I	22a Did tahaaa	a usa saatsibuta ta	the cause of death?
Records,	uires tha signed id be del	d by	Tarrit, other significant conditions con	minuting to death but not les	saiding in the anderlying	cause given in Fait i.	1 ☐ Yes		
Š	w requir s been si should	Completed					24a. Was an	24b. Were aut	opsy findings available
Re	The lay	mo					autopsy performed	death?	opsy findings available ompletion of cause of
İtal	ysicien: Th us certificete director, pag	Bec	25. Was case referred to medical examiner?			26. Place of Dear	th Check only one	103	2010
of Vital	Q 5 X	2	1 ☐ Yes 2 ☐ No		ER/Outpatient 3 1		ome 5 Residence	(-)	whospice
E C	ding P h. After funera	ion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Division	i or Attendi efter death. Director; A in by the fu	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, street, facto		28f. Location (Street	and Number or Rui	ral Route Number,
ā	s efte	Certification:	4  Homicide determined	building, etc. (Speci	ty)		City or Town, St	afe)	
	To the Huspital or Attending Ph within 24 hours efter death. To the Funerel Director: After th complete y filled in by the funeral		(Check only "2 Medical Examin	nician: To the best of my kni ner: On the basis of examina	owledge death conume ation and/or investigation	d at the time, date and place on, in my opinion, death occur	and due to the cause red at the time, date a	(t) and manner at and place, and due to	etalled to the cause(s)
	thin 2, the 1	Medicai	one)  29b. Signature and title of certifier	and manner stated.		9c. License number		Date signed (Month)	
	8 7 % 1		> S-TI 118	>	-	カコルノフカ		-	1
	1		30. Name and address of person who co	empleted cause of death (Ite	m 23a) (Type, Print)	טוודעע	D.	cember	8,2006
			E SOME R	cher Hospice	838 N	Eulaw St	Baltir	nore MD	21201
	Sta Registr		31. Date filed (Month, Day, Year)	32. Římstrar's Signi	ature Snaw	25			
	Tiegisti	aı I	DLU I N G	UUU A SEE SEE ASE	M. Marchan				

			1 - For State Registrar	State of	Marylan		artment of H				giene	06	39527
			1. Decedent's Name (First, Middle	, Last)						2. Date of Dea		Year	3. Time of Death
	Physici /Medio		Harold Ray	Gene Jei	nnings					Decemb			11:00 pm
100	Examin	4	4a. Fecility Name (If not institution	give street and num	ber)		4b. City, Town, o	or Location of	of Death		4c. County	of Death	Series -
			2551 Baltimore 5. Social Security Number		ailer #		Finksbur		24 Hrs	8. Date of Birt	Carr		alana (State on Consider
	Funeral Director		191–26–5786	1\X\ M 2□F	80 - Age	Yrs.	Months Days	Hours	Min.	Month, Day  July 2	v. Year)	Coul	place (State or Foreign ntry) SOUNI
			Usual Residence of Decedent							oury z	1320	-	
	atter death with the Marylan or Iteme 23a or 28a-f ehow iminer must be notified at	_	10a. State 10b. County		10c. City	y, Town or Lo	ocation						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	Ne Mi	Director	Maryland Carrol	1	Fin	ksburg					10- 00	140	
	a or 2		10e. Street and Number			. 40	10f. Zip Code				10g. Citizen of		ntry?
	ne 23	Funeral	2551 Baltimore	12. Was Deced	dent Ever in U.		21048 Was Decedent of H	Hispanic Ori	igin? (Spec	offy Yes or No-	U. S.		can Indian,
မွ	or Her	F	1 ☐ Never Married 2 💆 Marri	ed 1 X Yes	ces? 2 □ No		Was Decedent of I			Rican, etc.)		ick, White,	etc.
Maryland 21215-0036	hours after death with the Maryland turel', or Iteme 23a or 28a-f ehow al Examinar must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Da	tes: 19	944	1 ☐ Yes 2 🂢 No	Specify:			Specif	y: Wh	nite
5-0	72	Completed	15. Decedent (Specify only highes			(Give	dent's Usual Occup kind of work done	during mos	t of workin	g	16b. Kind of B	usiness/In	ndustry
121	d within giene. rr then	Ig II	Elementary/Secondary (0-12)	College (1-	4or 5+)		DO NOT use retire	d)			Steel		
d 2	be filed that Hygie d other	ပိ	17. Father's Name (First, Middle, I	Last)		TTUC	Driver	18. Mothe	er's Name	(First, Middle,	Maiden Sumar	me)	
au	a is b	To Be	Oscar Fields	Jennings				Iv	a Ma	e Gri	mm		
ary	2 shou and M ie mar aumat	-	19a. Informant's Name/Relationsh			19b. Maili	ng Address (Street					, State, Zij	<sup>o Code)</sup> 21048
Σ	12 = Z		Vernona Irene J	Gennings_(			Baltimor		d. I	railer	#42 Fi	nksbu	irg, MD
Baltimore,	0 O L		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 DRemoval from S	20b. P	lace of Dispo emetery, crea	osition (Name of matory or other pla	c <b>a</b> )		ate	20c. Location	- City or To	own, State
Ĕ	Pages ment of ent: If its ury or o		4 Donation 5 Other (S)		1	dens d	of Faith	Cem.	2866	2	Baltim	ore,	Maryland
Salt	permit. Page Department of Importent: if eny injury or once.		21. Signature of Funeral Service	icensee		Bi	2. Name and Addre	ss of Facili	eral	Home P	Α		5.535 S.W. 10.
	20 = 0		Michael C.	Jaffin	, Sr.	77	ayzdzinsk	aster	n Ave	nue E	ssex, M	aryla	and 21221
			23a. Part1. Enter the disease, or shock, or heart failure. List								rest,		Approximate Interval Between Onset and Death
	Physician /Medical		tmmediate Cause (Final disease or condition resulting in death)	a	ardi	o pul	monary	<i>T</i>	trre	ST			
	Examiner			Due to (c	A C L +	uende of):	sis						
	ŧ	e	Sequentially list conditions if any, leading to immediate	Due to (c	or as a consequ	uence of):							
	outed d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
ó	be executed sicien and burial-transit		resulting in death) Last		or as a consequ	uence of):							
8760,	ate hy	lcal		d									2
9	n certifica anding ph use as t	Physician/Med	IF FEMALE:	222 16 1122 2142		70. ==					* T	2.5	1.555
Вох	attend for us	lan	23b. Was decedent pregnant in the past 12 months?		th 2 ⊟Fetal antat time of de	death 3	Ectopic pregnanc Other (specify)	у				ate of delive onth	ery Day Year
P.O.	by the de	yslc	1 □ Yes 2 □ No 9 □ Unknown	9 Unknow		eatti 5	_ Other (specify) _						
	£ 88		Part II. Other significant condition	ns contributing to de	ath but not resi	ulting in the u	nderlying cause giv	ven in Part I		23e. Did to	obacco use con	tribute to t	he cause of death?
rds	aures on sign	ed by		<del></del>				4		1 🗆 Y	′es 2□No	3 Prot	bably 4 Unknown
of Vital Records,	law requir as been si 2 should I	Completed								24a. Was		Were auto	opsy findings available
æ	The Late ha	E								autop perfor	rmed?	death?	ompletion of cause of 2□ No
ita	ortifice ctor. 1	Bec	25. Was case referred to medical examiner?					26. Place	of Death	Check only o			
<u>&gt;</u>	ding Physicien: h. After this certific funeral director,	户	1 ☐ Yes 2 🛣 No			ER/Outpatie	IL 3LI DOX		ursing Hom	e 5 Resid	dence 6 Oth	ner (Specif	<b>(y</b> )
no O		Ë	27. Manner of Death 1 ØNatural 5 ☐ Pending		f Injury n, Day Year)	28b. Time o Injury	Wo			8d. Describe h	low injury occur	red	
isio	or is	cat	2 Accident Investig	ot be 200 Place	of Injury At he	amo form at		Yes 2		Of Location /6	Stroot and Numi	har as Pur	al Route Mumber
Division	il or Att after de Direct Jin by t	Certification:	4  Homicide determine	buildin	g, etc. (Specif)	y)	reet, factory, office		2	City or Tow	m, State)	Jei di nure	al Route Number,
	To the Hospital or Attuvithin 24 hours after de To the Funeral Direct completely filled in by the		29a. Certifier 1 X Cartifyin	g Physician: To the I	best of my kno	wledge, deat	h occurred at the ti	me, date an	nd place, ar	nd due to the	cause(s) and m	anner as s	stated.
	Pe Ho	edical	(Check only 2 Medical (one)	Examinar: On the ba	sis of examina	tion and/or in	vestigation, in my	opinion, dea	th occurre	d at the time,	date and place,	and due to	o the cause(s)
	To the To	X	29b. Signature and title of certified	1.0			29c. Licens	se number			29d. Date signe	d (Month,	Day, Year)
)	, 1		1 Cares	1 Shal			Do	3064	7780	7	Decemb	er 9.	2006
	12.41		30. Name and address of person	who completed cause	of death (Item	1 23a) (Type,				1			
	101		Dr. Naveed H.		. 224	Washir	ngton Hei	ghts	West	minster	Mary	Land	21157
	Sta Registi	_	31. Date filed (Month, Day, Year)	32. R	gistrar's Signa	iure	market						
	5.0.		DEC 1	4 LUUD AS	Bellowie d	54							

			For State Registrar	State of Marylan		artment of H rtificate of I		ı Mentai Hy	gien Reg. N	0000	20528
			Decedent's Name (First, Middle, Last	ot)				2. Date of De	eath	2000	3. Time of Death
	Physicia /Medic		JOSEPH SAMUEL J	OHNSON JR.				Decembe		ay Year 10 2006	11:08 AM
5	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of De	eath	4	c. County of Death	
ja .			UNION MEMORIAL HO		lact hinth days	BALTIM If Under 1 Year	ORE If Under 24 H	Irs. 8. Date of Bi	rth	O Birth	where (Ctate on Fourier
	Funeral Director		212-48-3053	ex 7. Age ( <i>In yrs</i> . ☑ M 2 ☐ F 59	Yrs.	Months Days		in. (Month, D	ay, Yea	r) Cou	place (State or Foreign intry) H CAROLINA
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				T	10d. Inside City Limits
	Maryl -f sho ied a	호	MD		ват.п	IMORE					1 ☐Yes 2 XNo
	r 28a	Director	10e. Street and Number		PAHI	10f. Zip Code			10g. C	itizen of What Cou	intry?
	23a o	a	4401 RITCHIE HWY.			21225			U	S.A.	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	ispanic Origin? an, Mexican, Pu	(Specify Yes or Numerto Rican, etc.)	0-	14. Race - Amer Black, White	
2-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Inmportant: if them 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1		1⊡Yes 2⊠No	Specify:			Specify: B	LACK
2	72 hc "natu dical	etec	15. Decedent's Ec (Specify only highest gra	lucation de completed)	i (Give	dent's Usual Occup	during most of t	working	16b.	Kind of Business/li	ndustry
7	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ine. i	DO NOT use retired	<i>1)</i>		[	OOD SERV	TOPO
ם ע	Hygid Hygid Sther ent, th		17. Father's Name (First, Middle, Last)		1	COOK	18. Mother's N	Name (First, Middle			ICES
<u>a</u>	lid be lental ked c ic ev	To Be	JOSEPH S. JOHNSON	SR.			MILDRE	D WHITE			
ary	should by and North	-	19a. Informant's Name/Relationship (	Type. Print)	19b. Mailir	ng Address (Street	and Number or	Rural Route Numi	ber, City	or Town, State, Z	ip Code)
Ξ.	and 2 ealth n 27 i		RODGER JOHNSON/BR				n Ave.				lst floor
e O	ges 1 t of He if Iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Dispo cemetery, crea	sition (Name of matory or other plac	ce)	Date	20c.	Location - City or 1	Town, State
Daltimor	t. Pag Imen Itant:		4 □ Donation 5 □ Other (Specif	y) MET		EMATORY				TIMORE,	
ם	permit Depar Impor any Ir		21 Supplies of Funeral Service Licen			2.Name and Addre VILLIAM C .206 W. No					
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not ent	er the mode of dyir	ng, such as card	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
F	Physician		immediate Cause (Final disease or condition resulting in death)	a. Hypotension	1						748hr
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):						>48 hr
		ē.	Sequentially list conditions, if any, leading to immediate	b. Sepsis Due to (or as a conseq	uence of):						770111
/	uted d ansit	Examiner	Cause (Disease or injury that initiated events	Liver failus	æ						1 month
ע כ	executer an and rial-trans		resulting in death) Last	Due to (or as a conseq	,						> 1 (1
> ,00/90	ificate be executed j physician and ss the burial-transit	edical		d. Renal fail	ure.						> 1 month
POX	death cert e attending d for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregn: 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c 9 ☐ Unknown	ıl death 3 🛭	⊒Ectopic pregnancy ☐ Other (specify)	у			23d. Date of deli Month	very Day Year
ecords, P.	requires that the een signed by the	by	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.				the cause of death?
Ö	law req as b <b>e</b> er 2 shou	Completed						24a. Wa		24b. Were au	topsy findings available ompletion of cause of
r	9 4 9	omp							opsy formed? 2 🖳	death?	ompletion of cause of 2☑•No
		Be C	25. Was case referred to medical examiner?				26. Place of	Death (Check only		10 100	
<u>-</u>	hysic nis ce I direc	To E	1 Yes 2 1 No	Hospital: 1 1 Inpatient 2	ER/Outpatie		4 🗆 Nursin	g Home 5 Res	sidence	6 ☐Other (Spec	sify)
0 0	ing P		27. Manner of Death 1 → Natural 5 → Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe	how in	jury occurred	
UNISION	ttend death. stor: / the f	icati	2 Accident investigation 3 Suicide 6 Could not b		ome farm st		Yes 2 □ No	28f Location	(Street	and Number or Ru	ral Route Number
2	i or A after Direc I in by	Certification:	4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	fy)	000, 140107, 011100		City or To	own, Sta	ate)	rai riodio rvarizos,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certification of the funeral director, to mpletely filled in by the funeral director,	edical C		nysician: To the best of my kno miner: On the basis of examina and manner stated.							
	o the	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. [	Date signed (Month	n, Day, Year)
)	F 5 F 0			M.	D.	AT 2	43894	6	De	cember, 1	0, 2006
7	3		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type,	Print) orial Hosp	ital M	D		,	•
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign.		1-00-					
	Regist		DEC 1 2 2	006 Lineur 1	K A	SALL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** W. Jennings, Sr. Dec. 2006 8:30 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Catonsville Baltimore Woodbridge Valley Manor Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1**∑**M 2□ F 218-05-4283 85 29, Jan. Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehromany injury or other traumatic event, the Medical European. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 X No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 303 Maiden Choice Lane Apt. 101 21228 USA Completed by Funeral 12. Was Decedent Ever 1942 – Armed Forces? 1942 – 1 Des 2 DNo 1945 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Railroad Carman Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jennings William Maude E. Barker ပ 19a. Informant's Name/Relationship (Type. Print)
Lillian V. Jennings, wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Maiden Choice Lane Catonsville, MD. 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 12-11-06 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Ambrose Funeral Home, Inc. 21. Signature of Funeral ervice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arbutus, M. Immediate Cause (Final DEMENTIA ZHEIME **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner sician and To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Unector: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 12 Nursing Home 5 | Residence 6 | Other (Specify) Hospital: 1☐ Yes 2☐ No 2 ER/Outpatient 3 DOA 1 Inpatient ို funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Medical Certification: Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Records, P.O. Box 68760, Division or Vital

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

29c. License number DU059107 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVE, REISTERSTOWN, MD 2-1136 BUSINESS CENTER UMA

Travon Lamar Johnson State of Maryland / Department of Health and Mental Hygiene  1- For State Certificate of Death															
	R	- For State eqistrar  . Decedent's Name (First, Midd	lo I ==#\		Cei	tificate	of Dea	tn		2. Date		. No. 20	06	R. Time of Deat	531
Physician/ Medical Examine	•		ama	r Jo	hns	00						Day Year 5, 2006	3	0016 hrs	ın
A second	4	la. Facility Name (if not institution Johns Hopkins Hospi						Town, or L	ocation of	Death		4c. County of	Death M / /	2	
Funeral	5	5. Social Security Number	6. Sex	7. A	ge (In yrs. 1a	ast birthda		der 1 Year	If Under :	24Hrs. 8. Date	of 8 irth			olace (State or	
Director	2	19-13-4243	1 M	2_F	19		Yrs. Mont	ths Days	Hours	Min. Max	Jh 8	1987	Foreign Coun	try) M	ク
ń	_	Usual Residence of Decedent  10a. State 10b. County			10c. City.	Town or L	ocation			-		-	11	0d. Inside City	v Limits
re Maryland or 28a-f show any fred at once.		MD A	1/2			B	attom	one						1 Yes 2	No
r death with the Maryland , or items 23a or 28a-f shu rmust be notified at once Funeral Director		0e. Street and Number	-1-					ip Code	7		100	Citizen of Wha		y?	
with the s 23a or notifi	5   4 8   1	3615 Breh		Was Deceden	nt Ever in U	S 13		2/2/		n? ( Specify Yes	or No-	USK	Amorico	ın İndian, 8lacı	:k
r death with th or items 23a must be noti	<u> </u>			Armed Forces		.0.				Puerto Rican, et		White,	etc.	van	Ν,
s after rral", o	⋧┞	3 Widowed 4 Div 15. Decedent's Education (Spe	orced If Yes	ates:	malotod)	160 000		<u>-</u>	specify:	nd of work done	. 1/	Specify  16b. Kind of Busi	m	in can	
5-0036 ed within 72 hours after gygene other than "natural", the Medical Examiner Completed by		Elementary/Secondary (0-12)		College (1-4 or			ng most of wo					TOD, KING OF BUSI		lustry	
0036 Within inchesion		88		,		<u></u>	La	bon				Con	s fa	wother	)
		7. Father's Name (First, Middle	- 4	son, J.	a.			18		Name (First, M		aiden Surname)			
AD 2121 2 should be fi h and Mental 27 is martic avent, To Be	2 [1	l 9a. Informant's Name/Relations	hip (Type, F	Print )				S (Street	and Numb	er or Rural Rou	te Numb	er, City or Town,	State, Z	(ip Code)	<b>a</b>
alti m s		20a. Method of Disposition	son /	mother	20b. I	Place of Di	615 sposition (Na	ame of ceme	etery,	Date	! છવ	HA one 20c. Location - C	ME City or To	own, State	10
Baltimore, permit. Pages I a Department of He Important: If ite		1 Burial 2 Cremation 4 Donation 5 Other S	_	emoval from S		My. 2	or other place	e) Panj	_ /	0/81/54	6	Sa W	4m	ne 14	0
Baltimo permit. Pag Department Important: Injury or ot	2	21. Signature of Furferal Sovice			I	7	22. Name an	d Address o	of Eacility	e. For	en	Sew.	ree	PIR	
Physician	1 2	23a. Part I. Enter the disease, or	complication	ns that cause	d the death.									Approximate I	
/Medical		failure. List only one cause Immediate Cause (Final disease	N.A IA	<sub>e.</sub> iple Gunsh	ot Woun	nds								8etween Ons Death	
zxammer		or condition resulting in death)		o (or as a cons	sequence o	f):									
ner	֓֞֞֜֞֜֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):													
ted Instit	Yall														
T a a a	<u> </u>	UNPENDED	d	ENDED											
60, ate be e hysicia e buria		F FEMALE:	23	c. If yes, outco	ome of preg	nancy						23d. Date of d	elivery		
the death certificate I by the attending physician the bysician/Me	2	3b. Was decedent pregnant in t past 12 months?	1 [	Live birth	at time of de	2 <u></u>	Fetal death		Ectopic p	oregnancy		Month	Day	y Yea	ar
Box e death the atte	<u> </u>	1 Yes 2 No 9 Un		Unknown		5	Other (Sp	ecity)							
Records, P.O. Box 68760, The law requires that the death certificate be excate has been signed by the attending physician page 2 should be detached for use as the burial completed by Physician/Medic		Part II. Other significant condi	ions conti	ributing to dea	ith but not re	esulting in	the underlyin	ng cause giv	ven in Part	1. 23e.		acco use contrib			
ords, law requires us been sign should be											. Was an	24b. We	ere auto	osy findings av	vailable
tal Records, rian: The law require certificate has been si ector, page 2 should b. Be Completed								<del></del>			autopsy perform Yes 2	ed? de	or to con ath? Yes	npletion of cau	use of No
		25 Was case referred to medica								heck only one)			7 100		-
of Viting Physici of After this connected directions on To E	١L	examiner?  1 ✓ Yes 2 No	Hospit	П	ient 2 🗸	ER/Outpa				Nursing Home			Other:		
Division of Vital Records, P.O. tall or strengther that it at for teath  **Borretor: After this certificate has been signed by led in by the funeral director, page 2 should be detacertification: To Be Completed by Fertification:		27 Manner of Death 1 Natural 5 Pen	ding	8a. Date of Inj Dec 6, 2006	Year)	2353 hr		28c. Injury	es 2 🗸 N	Subjec		w injury occurred	ı		
Division o spital or Attending hours after death neral Director: After the filled in by the function:	3		stigation Id not be	28e. Place of I	Injury - At ho	ome, farm,	street, factor	ry, office bu	ilding, etc.		ation (Str	eet and Number	or Rural	Route Numbe	er, City
<u></u>		4 Momicide		(Specify) Si						3437 Ke	nyon A	ve., Baltimore,			
Division of Vital Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director. Redical Certification: To Be	ק   פֿר	(Check only 1 Certifying Pone) 2 Medical Exa	miner:On t		amination a							s) and manner and place, and due			
10 10 Me	2	29b Signature and title of certifi		C .	100		29	9c License				29d. Date signed			
		tal linen	ilk	+96	let	10		O.C.M	1.E.			December 7	, 2006		
5	3	30. Name and address of persor Patricia Aronica-Polla		eted cause of Assistant I			er 111 F	Penn Stre	eet, Balt	imore, MD 2	21201				
State	e 3	31. Date filed (Month, Cay, Year)	2006	32. Kegistr	ar's Signatu	ire	( . v -					-			
Registra	11	2501 %	-AUUU	No. of the last	w so										

			Plea	ase Type or Pri					-		egible.	
			For State Registrar	State of M	ıaryıan		artment of F rtificate of	lealth and M Death	•	giene Reg. No	2006	30531
		-	Hegistrar     Decedent's Name (First, Middle)	lle, Last)			inouto or	Doui.	2. Date of De		_000	3. Time of Death
	Physici		Fronk I Vonne	a des					Dec. 1	Day	006 Year	7:45 A M
1	/Medic Examin		Frank J. Kenne  4a. Facility Name (If not institutio		')		4b. City, Town, o	r Location of Death	DCC. I	4-	County of Deatl	
	LAdiiii	CI	Gilchrist Cent	ter			Towson			Ba	altimor	2
-	Funeral	ă	5. Social Security Number	6. Sex 7. A	ge (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl	th V Voor	9. Birth	place (State or Foreign
١.	Director	20	055-30-8426	1 ☐ M 2 ☐ F	76	Yrs.	Months Days	Hours Will.	8. Date of Bird (Month, Da Oct. 1	0 193	30 New	York
	pu ,		Usual Residence of Decedent  10a. State 10b. County		100 Cit	y. Town or Lo	eation					10d Incide City Limite
	aryla shov	ř	Toa. State Tob. County	/	100.01	y, Town Or Lo	callon					10d. Inside City Limits 1 XYes 2 No
	he M 8a-f otifie	ectc		more City	<u>Ba</u>	<u>ltimor</u>				10- 011		
	with the or 2 or 2	Funeral Director	10e. Street and Number				10f. Zip Code				en of What Co	intry ?
	s 23e	eral	20 East Mount	Vernon Place		C 12	21202	diamonia Origina (Spe	sifu Vas ar Na		JSA 4. Race - Amer	ican Indian
	er de Item	Ę.	11. Marital Status 1 □ Never Married 2 XMar	Armed Forces	?	.5.	If Yes, specify Cub	lispanic Origin? (Spean, Mexican, Puerto I	Rican, etc.)	·   '	Black, White	
36	rs aft	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			1 ☐ Yes 2 <b>X</b> ☐ No	Specify: wh	ite		Specify: wi	nite
9	thou satura	ed	15. Deceder	nt's Education		16a. Dece	dent's Usual Occup	pation		16b. Kin	d of Business/I	
215	nin 7% In "na Media	plet	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4or	5+1	(Give life.	kind of work done DO NOT use retire	during most of workir d)	ng			
212	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show nnt, the Medical Examiner must be notified at	Completed	Elementary/decondary (0-12)	4+	VT/	Psych	ologist			Se1	f Prac	cice
Maryland 21215-0036	2 should be filed withir and Mental Hygiene.  is marked other than aumatic event, the Me	Be C	17. Father's Name (First, Middle,	, Last)		•		18. Mother's Name	(First, Middle,	Maiden S	Surname)	
<u>Ja</u>	uld b Menta arked	70	Frank J. Kenne	edy Sr.				Martha Ze	ller			
lan	2 sho and is ma	1 1	19a. Informant's Name/Relations	ship (Type. Print)			-	and Number or Rura				
	1 and 2 Health em 27		Rebekah Kenned	ly - Wife				t Vernon P				
ore	es 1 of H if iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from State		Place of Dispo cometery, cre	osition (Name of matory or other plac		ate	20c. Loc	ation - City or	own, State
Ë	Pages ment of h ant: If ite lury or of		4 ☐ Donation 5 ☐ Other (5	Specify)	Me		ematory	Dec.	11,06	Balt	imore,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	icensee		Ĉ	2. Name and Addre remation	Society o	f Mary	land,	Inc.	
	40 = 40		MIL	1246010	4	2	99 Fredei	rick Road	Baltim	ore,	MD 2122	
H			23a. Parv. Enter the disease, o shock, or heart failure. Lis	st only one cause on each	line.		_	ng, such as cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. LUN(	س سو	ANC	ER					6 marths
	/Medical Examiner		Tooding in dodding	Due to (or a	s a conseq	uence of):						
4		-	Sequentially list conditions,	b	s a consen	uence of):						
-	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unusing Cause (Disease or injury	\$ 500.10 (0) 0	o a conseq	deride oi).						
	be executed sician and burial-transit	xar	that initiated events resulting in death) Last	c Due to (or a	s a conseq	uence of):						
,09	be e sician buriz	<u>e</u>										
687	ficate physis the	edic		d								
Вох	The law requires that the death certificate to as reen signed by the attending physinage 2 should be detached for use as the I	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom						2	3d. Date of deli	very
Ď	death a atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant			⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	У			Month	Day Year
0	that the d ed by the detached	hys	9 Unknown	9□Unknown								
٦,	res tha igned I be det		Part II. Other significant condit					en in Part I.	23e. Did t	obacco us	se contribute to	the cause of death?
ë	w require	ed t	Metastases	to some	and	<u> </u>	en_		10	Yes 2	No 3□ Pro	bably Unknown
00	aw requisiteen	Completed by							24a. Was	an	24b. Were au	opsy findings available
Ĕ	The law	E							autoj perfo 1∐ Yes	rmed?	death?	ompletion of cause of 2 ☐ No
Vital Records,		a	25. Was case referred to medica	al				26. Place of Death			1 1 1 1 1 1 1 1	20110
>	di Si	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpat	tient 2	ER/Outpatie	nt 3□ DOA Oth	ner: 4 ☐ Nursing Hor	ne 5□Resi	dence 6	Other (Spec	ity HOSPICE
ו סר			27. Manner of Death 1 Natural 5 □ Pendi	28a. Date of In (Month, D	jury Jav Year)	28b. Time o Injury	f 28c. Inju	ry at 2	28d. Describe			
Ö		atic	2 Accident invest	tigation				lYes 2□No				
Division	after de after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	mined 200. Flace of It	njury - At he etc. <i>(Specif</i>	ome, farm, st	reet, factory, office	2	28f. Location (3 City or Tox			ral Route Number,
	urs after rai Dir		-	li li								
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ical	(Check only 2. Medica	ing Physician: To the bes al Examiner: On the basis	of examina	owledge, deal ation and/or ir	h occurred at the ti	me, date and place, a opinion, death occurre	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	the the the the the the the the the the	Medical	one)	and manner s	stated.		29c, Licens	se number		20d Data	eigned (Mo-4	Day Year
	7 wit	-	29b. Signature and title of certific	OO PO	Genl	200	250, LICENS	) E (042		Zad. Date	signed (Month	Lay, rear)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

And Cle Review Model Results Signature

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day 1. Decedent's Name (First, Middle, Last) Year **Physician** &AM Georgina Rae Kuczinski Decembe 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BAltemare Washington
5. Social Security Number 6. Sex Medical Centel zlen 21116 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Year) Days Months Hours Min 1 ☐ M 2 🛛 F 215-46-8462 60 09-23-1946 MD Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2X No Director MD Anne Arundel Severn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 799 Jennie Drive Items 23a 21144 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Never Married 2X Married 'natural", or 1 ☐ Yes 2 🔀 No Specify white þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Injury or other traumatic event, the 12 Data Analyst permit. Pages 1 and 2 should be filed verpartment of Health and Mental Hygis Important: If Item 27 is marked other? 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George R. Bowman Iris B. Webber 19a. Informant's Name/Relationship (Type. Print) husband/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Stephen Kuczinski, Jr. 799 Jennie Drive; Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5⊠Other(Specify)entombment Glen Haven Mem. Park: 12-12-2006 Glen Burnie, MD 21. Signatura of Fuperal Service Licensee 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medicai Due to (or as a consequence of): **Examiner** Sequentially list conditions, ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 ☐ Ectopic pregnancy for in the past 12 months? Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 □ Yes 2 🕱 No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼No 24a. Was an has autopsy performe 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🕅 Inpatient 2 ER/Outpatient 3 DOA ဥ filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier | Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier

State Registrar Julius

31. Date filed (Month, Day, Year)
DEC 1 2 2006

Glen Burne

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

36. Registrar's Signature

lease	Type of Print in Bia	ick indelible ink.	Ensure All C	opies Are	regio
	State of Maryland	Department of H	lealth and Men	tal Hygiene	UUt

			1- For Stata Ragistrar Amend #2:					Health and N Death		Reg. No.	Ub	39533				
п	Physici	ian	Decedent's Name (First, Middle,	Last)					2. Date of De Month	eath Day	Year	3. Time of Death				
	/Medi				. Kirkpa	atrick			Decem		2006	5:00 PM M				
8	Examir	ner	4a. Facility Name (If not institution,	give street and r	number)		4b. City, Town, o	or Location of Death		4c. Coun	ty of Death					
2.5	E	4	5. Social Security Number	dette R		s. last birthday)	If Under 1 Year	Bethesda If Under 24 Hrs.	8. Date of Bir	rth	Mont 9. Birth	gomery				
	Funeral Director		577-44-9410	1□M 2X F	80	Yrs.	Months Days	Hours Min.	(Month, Da	ay, Year) 19,1926		place (State or Foreign intry) Oklahoma				
	ס		Usual Residence of Decedent						TROVELIDE							
	shov	5	10a. State 10b. County		100.0	City, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 🕅 No				
	the N	Director	Maryland Mont	gomery			10f. Zip Code	Bethesda		10g. Citizen o	f What Cou					
	3a or	0		dotto D	a a d			20017		-		_				
	ns 2:	era	8709 Bur	12. Was De	cedent Ever in	U.S. 13.1	Was Decedent of H	20817 Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No			States ican Indian,				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "nature!", or items 23e or 28e-f show any highry or other treumatic event, the Medical Examinar must be notified at once.	by Funeral	1 Never Married 2 Marrie 3 Nidowed 4 Divorced	d 1 Tes	Forces? s 2 📉 No Give		f Yes, specify Cub 1 ☐ Yes 2 🕅 No		Rican, etc.)	Spec	ack, White ify:	, etc.				
Ö	hour ture!	q pa	15. Decedent's	Year or	Dates:	16a Decer	dent's Heural Occur	nation		16b. Kind of	Business/le	White				
21215-0036	in 72 n "na	Completed	(Specify only highest	grade complete		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of worl	king	166. Killa ol	DUSITIOSS/TI	lidustry				
212	d with piene.	E	Elementary/Secondary (0-12)		(1-4or 5+)		Ambas	sador		United	State	s Governmen				
	e file al Hyg r othe vent,	Bec	17. Father's Name (First, Middle, L	ast)				18. Mother's Nam	e (First, Middle							
Maryland	Ment Ment arked atice	2	W	elcher F	. Jorda	n			Blanch	e Leona	Kile	2				
lar	2 sh and ls m		19a. Informant's Name/Relationsh	p (Type, Print)				and Number or Rui				,				
	and Health I'm 27		Kevin Fay/ Att	corney	20h	25	West Mid	dle Lane,	Rockvi Date	11e, Ma	rylar	nd 20850				
Baltimore,	ages nt of } :: If it		1 ₺ Burial 2 ☐ Cremation		m State	cemetery, crer	natory or other pla	ce)								
ij	artme artme prtant injury		4 Donation 5 Other (Sp.		Pa	rklawn l	Memorial	Park 11,	2006	Pumphr	ville	, Maryland				
Ba	Depariment Department of the popular in popu		22. Name and Address of Facility Robert A. Pumphrey Fu Bethesda-Chevy Chase, Inc. 7557 Wisco Bethesda, Maryland 20814-3501													
	,		23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Application of the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, linter													
	Physician		Immediate Cause (Final disease or condition			_						Interval Between Onset and Death				
1	/Medical		disease or condition resulting in death)  Alzheimer's Disease Congestive Heart Failure  Due to (or as a consequence of):													
-	Examiner															
i u	pe #s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	o (or as a conse	quence of):										
-	be executed sician and burial-transit	хап	that initiated events resulting in death) Last	c	o (or as a conse	guence of).										
60,	be e sician buria	<u>ea</u>														
687	ficate physics the	edlc		o												
Box 687	n certi	Z/M	IF FEMALE: 23b. Was decedent pregnant		outcome of pregr		T-+:			23d. D	ate of deliv	rery				
	The law requires that the death certificate ate has been signed by the attending physogge 2 should be detached for use as the	by Physician/Medic	in the past 12 months? 1 □ Yes 2 No		gnant at time of		Ectopic pregnanc Other (specify)	y 		N	fonth	Day Year				
P.O.	at the I by th stach	Phys	9 Unknown													
	signed be det		Part II. Dther significant condition			sulting in the u	nderlying cause giv	ven in Part I.				the cause of death?				
O.C	w requir been si should I	eted	Heart Failure	(llear	)				113	Yes 2∏No	3   F10	babiy 4 □Unknown				
Records,	hysician: The law his certificate has b I director, page 2 s	Completed							24a. Was	DSV	. Were auto prior to co death?	opsy findings available ompletion of cause of				
alF	r: Th icate r, pag								perfo 1 ☐ Yes	2 <b>X</b> No	1 Yes	2 No				
Vital	Physician: this certificatal director, i	Be	25. Was case referred to medical examiner?  1 \( \sum \) Yes \( 2 \sum \) No	Hospital:		7	Ott	26. Place of Dear								
of	Phys r this	1: To	1 ☐ Yes 2 ☎ No 27. Manner of Death	1	Inpatient 2 [ of Injury onth, Day Year)	28b. Time of	I 3 DOA	4   Nulsing no		dence 6 \( \subseteq 0\) how injury occu		(y)				
ion	Attending or death. ector: Atterby the fune	atlor	1X Natural 5 ☐ Pending 2 ☐ Accident investiga		onth, Day Year)	Injury	28c. Inju	rk?  Yes 2 □ No								
Division	Attended of the py the	Certification:	3 Suicide 6 Could no 4 Homicide determin	28e. Pla	ce of Injury - At I	home, farm, str	eet, factory, office		28f. Location ( City or To	Street and Nurr	ber or Rur	al Route Number,				
Ö	rs afte si Dir ed in t	Cerl		001	iding, atc. (Space	y)			Only or 70	wn, State)						
	To the Hospitel or Attending Ph within 24 hours after death. To the Funers! Director: After thi completely filled in by the funeral.	Medical	29a. Certifier 1X Certifying (Check only one) 2 ☐ Medical E	xaminer: On the	he best of my kn basis of examin anner stated.	nowledge, death nation and/or inv	occurred at the treestigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and n date and place	nanner as s , and due t	stated. to the cause(s)				
	To the within 2 To the complet	Me	29b. Signature and title of certifier	31.00 1110			29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)				
	17		· Card	1.4	OM H	ni		11853		Dec	emher	8, 2006				
•	3		30. Name and address of person w	ho completed ca	use of death (Ite	m 23a) (Type,	Print)	-1000		Dec	CIIIDEL	0, 2000				
			Carol Horn, M.				.W. #200	Washingto	on, D.C.	20036	-3615					
100 A	Sta Regist		31. Date filed (Month, Day, Year)	2000	Registrar's Sign	ature	de la									

			For State	State of Ma	aryland / De	partm ertific	ent of H	lealth and	Mental Hy	Bra		39534	
			- State Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)							Reg. No.  2. Date of Death  3. Time of Death			
	Physici /Medi		CHARLES J. KIRCHER, SR.							December 8 2006 03:14a			
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of E								County of Dear		
			GREATER BALTIMORE MEDICAL CENTER TOWSON							BA	ALTIMORI	E	
	Funeral Director		5. Social Security Number 218-10-9430  6. Sex 1 M 2 F  7. Age (In yrs. last birthday, 85 Yrs.				hs Days	8. Date of Bi (Month, D 5/23/	(Month, Day, Year)		thplace (State or Foreign buntry) RYLAND		
	land	by Funeral Director	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits	
	with the Marylan a or 28a-1 show Le notified at		MD BALTIMORE PARKVILLE 1 Tyes 2 1/2 No										
			10e. Street and Number 10f. Zip Code 10g. Citizen of What Coun								puntry?		
	23a c	aiD	1718 RED OAK ROAD 21234								USA		
	ss 1 and 2 should be filed within of Health and Mental Hygiene. If them 27 is marked other than r other traumatic event, It a Ma	nuel		12. Was Decedent E Armed Forces? 1 ∑ Yes 2 □ N	ever in U.S. 1	or in U.S.  13. Was Decedent of Hispanic Origin? (Sinf Yes, specify Cuban, Mexican, Puerto				0-	14. Race - Ame Black, Whit		
36		To Be Completed by F	1 ☐ Never Married 2 ⚠ Married 3 ☐ Widowed 4 ☐ Divorced	lo I							HITE		
E 5-0036			15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business/In										
215			(Specify only highest grade completed)  [Give kind of work done during most of working life. DO NOT use retired)  [Elementary/Secondary (0-12)   College (1-4or 5+)										
2			8TH GRADE PRINTER								PRINTING		
and D			17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle	, Maiden	Sumame)		
/ 5			JACOB C. KIRCHER  AGNES KEENE  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co									7-0 //	
			IRENE E. KIRCHER/				D OAK		ALTIMORE				
MiRCHCR Baltimore, Mary			20a. Method of Disposition		20b. Place of Dis	position /		1	Date		cation - City or		
€ ii			1 ☐ Burial 2 🛣 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1			INC. 12	/9/2006	CAT	ONSVILL	E, MD	
alt	permit. Page Depertment important: financiant: fant injury o		21. Signature of Europe Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A.										
	70'E # 9		8521 LOCH RAVEN BLVD. TOWSON, MD 21286										
	Physician /Medical Examiner		23a. Bart. Enter the disease, or complications that caused the death. Do not enter a mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final										
>			immediate Cause (Final disease or condition resulting in death)  Due to (as a consequence of):										
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Вох	eath certii attending for use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1□ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy							2	ivery		
0.	the at	Physician/M	in the past 12 months? 1 ☐ Yes 2 ② No 9 ☐ Unknown	4☐Pregnant at t 9☐ Unknown		Other					Month	Day Year	
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rds		ed by								1 Yes 2 PNo 3 Probably 4 Unknown			
8		Completed		-					24a. Was	an	24b. Were au	topsy findings available	
Ä	The lay ate has page 2	E O							autor perfo	rmed?	death?	completion of cause of 2 No	
/ita	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?					26. Place of Dea	ath Check only			20110	
of,	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	2	1 163 2 140	spital:				4 🗀 Nursing F	lome 5 ☐ Resi			cuty)	
o		tion	27. Manner of Death  1. Astural 5 Pending (Month, Day Year)  28b. Time of Injury Work?  28c. Injury at Work?  28d. Describe how injury occurred  1 Yes 2 No										
<u>Ki</u>		ifica	3 Suicide 6 Could not be 28e Place of Injury. At home farm street factors office.								Number or Ru	ral Route Number.	
A building, etc. (Specify)								vn, State)	, State)				
	e Hosp 24 hou e Funet letely fil	Medical Certification:	29a. Certifier  (Check only one)  (Check one)										
29b. Signature and title of certifier 29c. License number									29d. Date signed (Month, Day, Year)				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PATEGO PATAOL 126 OUTER HEIGHTS ROAD, OWINGS WITH STAND AND AND AND AND AND AND AND AND AND							2/08/	08/2006				
1	12		30. Name and address of person who cor		ath (Item 23a) (Type	e, Print)	701	TC DOA	• •				
	Sta	te	31. Date filed (Month, Day, Year)		's Signature	- 67	CIMM	is KUP	P, UWII	143	nius,	MD 2147	
	Registra		DFC 1 2 2006	The pas	15 160	BOS CAN							

State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death December Day 10,2006 **Physician** 1:00 AM MARION KACHER RUTH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Edenwald Towson Months Days Hours Min. 3. Date of Birth July 19, 19, 19, 18 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2**X** 021-18-0580 88 Yrs Massachusetts Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the McCical Examiner must be notified at 10a. State 1 Yes 2 No Director Towson Maryland | Baltimore 10e Street and Number 10f Zin Code 10g, Citizen of What Country? #706 21286 USA 800 Southerly Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White Specify: Be Completed by 3√Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of 1 and 2 should be Genevive Marion (Unk.) Raymond Tobey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR 909 K Street Penrose Colorado 81240 Cheryl R. Kacher Health item 27 i other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ö XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) = 5 permit. Page Department. Important: if any injury or Parkwood\_Cemetery Parkville, Maryland 12/16/06 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 luare 23a. Part 1. Enter the alsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Betwee Onset and De Immediate Cause Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Entry Underly Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 ANo 23d Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 2**N**0 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{Yes} \quad 2 \subseteq \text{No} \) 24a. Was an page certificate 1 ☐ Yes 2 or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28c. Injury at Work? 27. Many er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Accident hours after death uneral Director: the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of a ertifie 16 N. Kolly Rd Bulby My 2/228 workey 31. Date filed (Month, Day, Year) State Registrar

06-09345 Joyce Ann Leonard

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

oyce Ann Leor	iaia	1- For State Registrar	e or maryiand / i		ficate of E		iu ivientai r	, ,	eg No. 🤈 🗅	00 0000		
Physici		Decedent's Name (First, Middle,L	ast)	-				2. Date of Dea	th 4	3. Time of Death		
Medical Exam	iner	Joyce A. Leonard	d					Month Decembe	r 7, 2006 Year	0911 hrs		
per -		4a. Facility Name (if not institution, g				•	Location of Dea	th	4c. County of			
		Washington County Hos	<u> </u>	_		Hagerstow	n		Washingt			
Funeral		Social Security Number     6.	Sex 7. Age (	In yrs. last	-	If Under 1 Year Months Day			rth(MM/DD/YYYY)	9 Birthplace (State or Foreign		
Director		215-86-1132	M 2 X F	40	Yrs.	MODITIS   Day	rs Hours Mi		9, 1966	Country) MD		
,		Usual Residence of Decedent	1						,			
w any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  1 Yes 2 X No										
Aaryland 28a-f show 1 at once.	Ö	MD Washin	gton	На	gersto							
Mary 28a-	Je C	10e. Street and Number			1	0f. Zip Code		1	0g. Citizen of Wha	t Country?		
th the Maryland 23a or 28a-f sho notified at once.	Ö	136 South Potoma	ac Street			21740			USA			
w <sub>i</sub> w <sub>i</sub>	<b>Funeral Director</b>	11. Marital Status  1 X Never Married 2 Marrie	12. Was Decedent Ev	er in US.	13. Was [	ecedent of Hi	spanic Origin? ( § n, Mexican, Puert	Specify Yes or No	14. Race - White,	American Indian, Black,		
r death or iter	Ē		1 Yes 2 X	No								
hours afte 'natural'', Examiner	by	3 Widowed 4 Divorce  15 Decedent's Education (Specify	ed If Yes, Give Year or Dates:				specify: wh		Specify:			
hour 'natu	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)				tion (Give kind of . DO NOT use re		16b. Kind of Busi	ness/Industry		
15-0036 filed within 72 I Hygiene. ed other than "		10	College (1-4 of 5+)		II om om - 1							
4 with		17. Father's Name (First, Middle, La	st)		Homema1	ker	18 Mother's Nam	e (First Middle I	Home Maiden Surname)			
21215-0036 uld be filed within ? Mental Hygiene. marked other than	Be C	Joseph E. Leonar				- 1			maider, darriame,			
2121 Muld be fil Mental I marked c event,		19a. Informant's Name/Relationship		1	19b. Mailing A	dress (Stree	et and Number or	Mulroy Rural Route Nur	nber, City or Town,	State, Zip Code)		
MD 2 and 2 shou asth and N m 27 is n aumatic		Katia Pule - Dau	ighter	1.7	742 A	Spruce	Stroot	Hacorat	own MD	217/.0		
tra de an		20a. Method of Disposition			ce of Dispositionatory or other	n (Name of ce	metery,	Date	20c. Location - C	City or Town, State		
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Baltimore, permit Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Special Signature of Funeral Service Lice		/ nett	o Crema		neral H	c. 15, 0	b Baltır	more, MD		
injur De per De injurie		1/2000	- 40 -		301	Fredor	meral H	ome, P.A	 	0.21220		
Physician		301 Frederick Road Catonsville MD 21228 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interval										
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Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	X UNPENDED	AMENDED #23a	27 28	-f rord	F ~963	1/5/07 T					
760, zate b physic he bu	ğ	IF FEMALE:	23c. If yes, outcome	of pregnan	cy	E, 2003.	1/3/0/ 1		23d. Date of de	elivery		
Box 68760 e death certificate b the attending physi	jan/	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fetal	death 3	Ectopic pregn	ancy	Month	Day Year		
lox 68° eath certiff	Sic	1 Yes 2 No 9 V Unknow	4	e of death	5 Other	(Specify)			200			
O. B. t the de by the ached f	Physician/	Part II. Other significant conditions		it not resul	ting in the und	erlying cause o	niven in Part I	23e Did to	hacco use contribu	ite to the cause of death?		
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Division  To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	ष्ट	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
To the within To the comple	Medical	, Z W modisal Examin	and manner stated.	anon and/0	. myosugation			at the time, date i				
	2	29b. Signature and title of certifier				29c. Licens			l	(Month, Day, Year)		
		Humith I wuthalf	(mi)			O.C.I	VI. □.		December 8,	2006		
		30. Name and address of person who			•	) O'	D-10	4D 01051				
t	ا	Pamela E. Southall, MD	Assistant Medica		ner 111 F	enn Street	t, Baltimore, I	VID 21201				
	ate	31. Date filed (Month, Day, Year)  BEC 1 2	32. Reflistrar's	Signature	has	K)						
Regist	ve l	DEGTS	.000	J /4	- 12				<u></u>			

State of Maryland / Department of Health and Mental Hygiene 39537 Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Dec. 9:51 P M 2006 Dorothy Little Reginia 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8141 Quarterfield Farms Drive Severn Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day June 29 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 X F 219-07-9718 85 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8141 Quarterfield Farms Drive 21144 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White <u>م</u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Howard McNelly ဥ Margaret Schmidt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sharon Hurd / Daughter 8141 Quarterfield Farms Drive Severn MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dec. 1 Burial 2 □ Cremation 3 □ Removal from State Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2006 Maryland Veterans Cemi 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Singleton Funeral Home, P.A. 1 Second Avenue Sw Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cane weeks /Medical Due to (or as consequence of) Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: detached for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknowr been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒ No 24a. Was an certificate has 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 5 Residence 6 □Other (Specify) Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0038912 06 aminez Rev 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 307 ALVACION 31. Date filed (Month, Day, Year) 32 Registrar's Signature State **DEC 1 2** 2006 Registrar

		State of Mar State Amend item # 1,29c, perMD, G Registrar	002, 1	Certific	ate of	Deatl	7		Reg. No.	006	39538
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Herbert Blan Law Bla	ir Her	bert Law				2. Date of De Month	Day 27	Year <b>2006</b>	3. Time of Death   8 20/620 M
Examin		4a. Facility Name (If not institution, give street and number) University of Maryland Medical Cente	-	4b. (	City, Town, o				4c. C	ounty of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (	In yrs. last	birthday) If Ui Mon	nder 1 Year		r 24 Hrs.	8. Date of Bin (Month, Da Oct. 1	av. Year)	9. Birthp	olace (State or Foreign ntry) nsylvania
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2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	or	Maryland   Carroll		own or Location						1	1 ☐ Yes 2 No
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yar.	by Funeral	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ev Armed Forces?  1 ★ Yes, Give Year or Dates:	WW II	1 D V	ecedent of Fi specify Cuba s 2X No	Specif		ecify Yes or No Rican, etc.)		Black, White,	etc.
"natur	leted	15. Decedent's Education (Specify only highest grade completed)	16	6a. Decedent's (Give kind o life. DO NO	Jsual Occup work done	ation during me	st of work	ing	16b. Kind	of Business/Inc	dustry
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Important: I any injury o		21. Signature of Funeral Service Licensee  Person Sname and	chi		e and Addre Ritch					Service, Maryl	e, P.A. land 21225
88		23a. Part : Enter the disease, or complications that caused the Hock, or heart failure. List only one cause on each line.	e death. D	o not enter the	mode of dyir	ng, such a	as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
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the attending p hed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal dea	ath 3□Ectop	ic pregnanc r <i>(specify)</i> _	у			23	d. Date of delive Month	ery Day Year
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or this certificate has aral director, page 2	유	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 27. Manner of Death 28a. Date of Injury	281	b. Time of	DOA Oth	4 🗆 1	Nursing Ho	ome 5 Res		Other (Specif	(y)
ath.	ation	1 Matural 5 ☐ Pending (Month, Day 1 2 ☐ Accident investigation	Year)	Injury M		k? Yes 2[	□No				
Director in by the	ertific	3 Suicide 6 Could not be determined 28e. Place of injury building, etc.	/ - At home, (Specify)	farm, street, fa	ctory, office				(Street and wn, State)	Number or Rura	al Route Number,
within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical Certification:	29a. Certifier (Check only one)  1 □ Certifying Physician: To the best of e and manner state	xamination	dge, death occu and/or investig	rred at the ti ation, in my	me, date opinion, d	and place, eath occur	and due to the	cause(s) a , date and p	ind manner as s place, and due to	stated. to the cause(s)
within To the	Me	29b. Signature and title of certifier			29c. Licens	e numbe	P211	186		signed (Month,	Day, Year)
		adom B. Edwards , M			AUYI	7643	5E17	411	11/2	7/2006	
2		30. Name and address of person who completed cause of dea Adan Edwards 22 S. Green St., E			20						
	ite	Adan Edwards 22 S. Green St. E  31. Date filed (Month, Day, Year)  DEC 1 2 2006  32 Registrar	s Signature	- 110							

DHMH 17 Rev 1/2001

			1- State of Marylan State of Marylan	d / Depa <i>Cer</i>	artment of Heal tificate of Dea	th and Me ath			39539
			Decedent's Name (First, Middle, Last)				2. Date of Death	j. No.	3. Time of Death
	Physici /Medio		Allan Douglas Macy			N	Month November	29, 2006	11:45 AM <sup>M</sup>
* *	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Local	ition of Death		4c. County of Death	
			549 N. 1st Street		LaVale	ndas 04 Usa		Allegan	
	Funeral Director		5. Social Security Number 6. Sex 1 № M 2 ☐ F 7. Age (In yrs. In the second security Number 76	ast birthday) Yrs.		nder 24 Hrs. ours Min.	B. Date of Birth (Month, Day, Y Oct 25,	(ear) 9. Birthp Cour 1930 Mar	place (State or Foreign http) 'Yland
	pu *		Usual Residence of Decedent  10a. State 10b. County 10c. Cit	r, Town or Lo					
	Maryla f sho	ō	MD Allegany	LaV				'	1 ☐ Yes 2 ☑ No
	28a-	rect	10e. Street and Number	Бау	10f. Zip Code		100	. Citizen of What Cour	
	th with	ai Di	549 N. 1st Street			21502		US.	•
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?		Vas Decedent of Hispanie Yes, specify Cuban, Me	ic Origin? (Spec exican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Americ Black, White,	
5	urs afte	by F	1 □ Never Married 2 M Married 1 M Yes 2 □ No If Yes, Give Year or Dates: * 52 – 1	5/1	☐ Yes 2🎇 No Spe	ecify:		Specify: wh	iite
5	2 hou	ted	15. Decedent's Education	16a. Deced	ent's Usual Occupation		16	6b. Kind of Business/Inc	dustry
7	ithin 7 nen "r Med	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life. L	kind of work done during OO NOT use retired)	most of working	7		
7	iled w tygier ther th	Co	12 4 17. Father's Name (First, Middle, Last)	rea	Ltor	4-46	(2) 14 14 14	proper	ty
5	d be f	) Be	Albert Hall Macy				<i>First, Middle, Ma</i> :h Somer	,	
<u> </u>	should be nd Mental i marked c	7	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and No				(Code)
Ž	and 2 ealth a n 27 is		Joyce B. Macy/spouse		. 1st Stree			21502	333,
ני כ	of He of He f Item		20a. Method of Disposition 20b. Pl 1 □ Burial 2 □ Cremation 3 □ Removal from State	ace of Dispos	sition (Name of natory or other place)	Da		c. Location - City or To	wn, State
	. Pages tment of I tant: If It jury or o		4 ☑Donation 5 ☐ Other (Specify)						
D	permit. Depertr Importa any inju		21. Signature of Funeral Service Licenses Wade, Director		Ale Anatomy Ltimore, MD		655 W. B	altimore S	treet
			234. Part1. Enter the disease, or complications that caused the death shock, a heart failure. List only one cause on each line.				respiratory arrest	t.	Approximate Interval Between
Ę.	Physician		Immediate Cause (Final disease or condition	7701	Failus	25			Onset and Death
ł	/Medical Examiner		resulting in death)  Due to (or as a consequ	ence of):	7.60		(	7	
		75	Sequentially list conditions, if any, leading to immediate	ence of):	SIRVEN	e y	ucmai	AM VOK	Chospatico
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	3.103 31).				)	
ב ב	an an	Еха	resulting in death) Last	ence of):					
	ficate be executed physician and s the burial-transit	edicai	d	<u></u>					
	ding p		IF FEMALE: 23c. If yes, outcome of pregnar	NOV.					
2	atten d for u	cian	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
į	t the c by the tachex	Physician/M	9 ☐ Unknown 9 ☐ Unknown						
ć	res that the death certifigned by the attending be detached for use a	þ	Part II. Other significant conditions contributing to death but not resu	fting in the un	derlying cause given in P	Part I.		cco use contribute to th	
5	w require been si should b	eted	Liborespos				1 X Yes	2 No 3 Prob	ably 4 □Unknown
	ralcian: The law s certificate has t director, page 2 s	Completed					24a. Was an autopsy performe	prior to con	osy findings available appletion of cause of
9	en: T tificate tor, pa	0	25. Was case referred to medical		26 P	Place of Death (		No 1 ☐ Yes	2 No
	nysici nis cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑	R/Outpatient	Other			e 6 □Other (Specify	·····
	iding Ph th. After th funeral		27. Manner of Death 1 分 at 1 → Death 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		d. Describe how		<u></u>
2	death death stor: /	icati	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2		(1 - 1) (0)		
2	s efter if Direct of in by	Certification	4 Homicide determined 28e. Place of Injury - At hose building, etc. (Specify,	ne, tarm, stre	et, factory, office	28	City or Town, S	et and Number or Rura. State)	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certiful 24 hours elder death within 24 hours elder death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medicai (	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	rledge, death on and/or inv	occurred at the time, date estigation, in my opinion,	te and place, and death occurred	d due to the caus at the time, date	se(s) and manner as sta and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	bin	29c. License numb	ber	29d.	Date signed (Month, L	Day, Year)
			1 Deer Wes	1	D3187	5	000	CHBOR 4	2006
			30. Name and address of person who completed cause of death (Item  Robert A. Welik Cumbe		, MD. 21502				
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signati	ite	M. 1				
	Registra	ar	DEC 1 2 2006 Lane A	Sport	Walter of the Control				

06-09002 Donald Martin

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Johana Wartin		1- For State Registrar	ate of Maryland	•	icate of Dea			g No 200	6 2051
Physic		1. Decedent's Name (First, Middl					Date of Deat     Month		3. Time of Death
Medical Exam	ıner	Donald Martin  4a. Facility Name (if not institution		-)	I dh. C hu	, Town, or Location of D	Month November	26, 2006 4c County of Deatl	0802 hrs
		38 North Curley Stree	_	,		imore			
Funeral Director		5. Social Security Number unk	6. Sex 7. A	ge (In yrs last) 78	oirthday) If Ur Mor Yrs.	nder 1 Year If Under 2 ths Days Hours	4Hrs. 8. Date of Birt Min. unk	Foreig	rthplace (State or unk gn puntry)
à		Usual Residence of Decedent  10a. State 10b. County		Inc City To	wn or Location				10d Inside City Limits
Maryland 28a-f show any d at once,		MD		loc. Oily, rol	Baltime	ore			1 X Yes 2 No
arylan 8a-f st at onc	Director	10e. Street and Number				ip Code	10	g Citizen of What Cou	ntry?
ith the Maryland 23a or 28a-f sho notified at once.	Dire	38 N. Curley	Street			21224		HOA	
e, MD 21215-0036  I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyggene (riem 27 is marked other than "natural", or items 23a or 28a-f she rrannante event, the Medical Examiner must be notified at once	Funeral	11 Marital Status U	nk 12. Was Deceder Armed Forces	? un		dent of Hispanic Origin? cify Cuban, Mexican, Pu		14. Race - Amer White, etc	rican Indian, Black,
ter des ", or i		3 Widowed 4 Divi	1 Yes 2	No No	1 Yes	2 X No specify		Specify. whi	<b>.</b> .
urs afi itural	d by	15. Decedent's Education (Spec	or Dates:	mpleted) 16	a. Decedent's Usu	al Occupation (Give kind	d of work done	16b. Kind of Business/	
36 in 72 bo nan "na lical Es	Completed	Elementary/Secondary (0-12)	College (1-4 or		during most of w	rorking life. DO NOT use	e retired)		dir
5-0036 led within 72 Hygiene other than the Medical	mo	unk 17. Father's Name (First, Middle,	unk Last)			18 Mother's N	lame (First, Middle, M	laiden Surname)	
D 21215-00; should be filed with and Mental Hygiene 7 is marked other th	Be C	(7. Fable) & Marie (Fried, Middle,	2001)			unk   18 Mother's N	tame (1 mar, Miradie, M	laideir Surriame)	unk
2121 ould be fill Mental B s marked ic event,	ToE	19a Informant's Name/Relations	nip (Type, Print )		19b. Mailing Addre	ss (Street and Number	r or Rural Route Num	ber, City or Town, State	z, Zıp Code)
and 2 shou cealth and 7 tem 27 is r		O.C.M.E.				enn Street	Baltimore,	MD 21201	
ore, Mes land 2 of Health If item 2		20a Method of Disposition  1 Burial 2 Cremation	3 Removal from S	I	e of Disposition (N natory or other place		Date	20c. Location - City or	Town, State
Pages   Pages   nent of F		4 Donation 5 X other So	ecify in state	<b>I</b>	,				
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene Importants: If item 27 is marked other than injury or other traumatic event, the Medical		21. Schature of Functil Service	Licensee Wade Din		State	Anatomy Bo	ard 655 W.	Baltimore	Street
Physician	*	23a Part I. Enter the disease or	complications that cause	d the death. Do	not enter the mode	ore, MD 2 e of dying, such as card	1201 ac or respiratory arre	st, shock, or heart	Approximate Interval
/Medical Examiner		failure. List only one cause Imme to the Cause (Final disease	<sub>a.</sub> Atherosclerotic	Cardiovaso	cular Disease				Between Onset and Death
Examiner		or con Hion resulting in death)	Due to (or as a cons						
	<u>ا</u>	Sequentially list conditions, if any, leading to immediate	b	and and a of \:					
	nin	cause Enter Underlying Cause (Disease or injury that initiated	C.	sequence or,					
ed	Examiner	events resulting in death) Last	Due to (or as a cons	sequence of);					
0, s be execute ssician and burial - tran	/Medical	UNPENDED	d AMENDED				•		
760, ircate be physical the burnithe	/Me	IF FEMALE	23c. If yes, outco	me of pregnand	су			23d. Date of delivery	/
ox 68; ath certifi attending or use as	sician	past 12 months?	1 Live birth	t time of death	2 Fetal deat		egnancy	Month [	Day Year
Box 68: death certif	ysic	1 Yes 2 No 9 Unk	nown 9 Unknown		5 Other (Sp	ecify)			
that the d	/ Phy	Part II. Other significant conditi	ons contributing to dea	th but not result	ting in the underlyii	ng cause given in Part I	23e. Did tob	pacco use contribute to	the cause of death?
res the signed be de	d by	Chronic Alcohol Abus	е				1 Yes	2 No 3 Prob	pably 4 🗸 Unknown
Division of Vital Records, P. ral or Attending Physiciau: The law requires the rs after death  "I Director. After this certificate has been signe (ed in by the funeral director, page 2 should be de	Completed						24a Was a autops		topsy findings available
Reco The law cate has	E E						perform	ned? death?	
tal R ciau: T certifica ector, pa	Be C	25 Was case referred to medical				26.Place of Death (Ch	5-13		2 110
Vita hysici this ca I direc	0	examiner?  1 Yes 2 No	Hospital 1 Inpati	ent 2 ER	Outpatient 3	DOA Other N	ursing Home 5 F	Residence 6 🗸 Other	Scene
n of ding Phy After ti	Ë	27. Manner of Death	28a. Date of Inj (Month, Day,	ury 288 Year)	o. Time of Injury	28c. Injury at Work?	28d Describe ho	ow injury occurred	
ion trend leath tor:	atio	1 Natural 5 Pend 2 Accident Inves	ing tigation			1 Yes 2 No			
Divis pital or At ours after d eral Direc	tific	3 Suicide 6 Could	d not be 28e. Place of I	njury - At home	farm, street, facto	ry, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Ru	ral Route Number, City
Division Hospital or Attenc 24 hours after death Funeral Director: rely filled in by the	Certification:	4 Homicide	mined (Specify)						
the Ho hin 24 the Fu	Medical		niner: On the best of miner: On the basis of exa	amination and/o					
To To con	Me	29b. Signature and title of certifie	and manner stated	1/	2	9c License number		29d Date signed (Mor	nth, Day, Year)
			M. /			O.C.M.E.		November 26, 20	006
		30 Name and address of person		death (Item 23a	1)				
-		·	uty Chief Medical E			eet, Baltimore, MD	21201		
	tate	31 Date filed (Month, Day, Year)	2006 32 Registra	ar's Signature	Sparke				
Regis	trar	DEO T N	POOL VERLEY	- OF T	1				

06-09310 Milton L. Moore Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

IIION E. WOOIE		1- For State Registrar	e or Maryland / Depa Ce	rtificate of Dea		30	eg. No. 200	6 3954
Physicia ledical Exami		1. Decedent's Name (First, Middle, La Milton L.	ast) Moore			2. Date of Dea Month Decembe	ith	3. Time of Death
		4a Facility Name (if not institution, g	ive street and number)		, Town, or Location		4c. County of Death	
Funeral		Prince George's County  5. Social Security Number 6.	Hospital Sex 7. Age (In yrs. I		everly	er 24Hrs. 8. Date of Bil	Prince George	
Director		260-04-6913	X M 2 F 50	Yrs			Foreig	
nd show any ice.	_	10a. State 10b. County		Town or Location  Jpper Marik	oro			10d Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 13109 Bar Gees	e Court	10f. Z	ip Code 20774	1	0g. Citizen of What Cour USA	ntry?
r death wi	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorce	12. Was Decedent Ever in U Armed Forces?  1 X Yes 2 No If Yes, Give Year 1975–1 or Dates:	If Yes, spe		gin? ( Specify Yes or No n, Puerto Rican, etc.)	White, etc.	can Indian, Black,
hours a		15. Decedent's Education (Specify	only highest grade completed)	16a. Decedent's Usus during most of w	al Occupation (Give orking life, DO NOT		16b. Kind of Business/I	ndustry
215-0036 be filed within 72 ntal Hygiene ked other than "ent, the Medical I	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	_	ergyman	,	Minis	try
ore, MD 21215-0036 es I and 2 should be filed within 72 hours after of Health and Mental Hygiene If item 27 is marked other than "natural", her traumatic event, the Medical Examiner	o Be Co	17. Father's Name (First, Middle, Las Bobby L. Moore  19a. Informant's Name/Relationship	e Sr.	40b MaiTa a Adda	Dor			
, MD 2 and 2 shoul saith and N em 27 is n raumatic	ř	Eve J. Moore Eva D. Moore  20a. Method of Disposition	Wife	13109 Ba	r Geese (	Date	nber, City or Town, State r Marlboro,	MD 20774
Baltimore, MC permit Pages   and 2 s Department of Health a Important: If item 27		1 Burial 2 Cremation 3 4 Donation 5 Other Specification	X Removal from State F1C	pral Memory	Gardens	12/14/2006		
			lloustrall	Charle	ast Fort	rens Funera. Avenue, Ba	l Home Inc. Ltimore, MD	
Physician /Medical	5 6	23a. Part I, Enter the disease, or comfailure. List only one cause on e	plications that caused the death each line. Gunshot Wound of Hea		e of dying, such as c	ardiac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a consequence or					
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence or	f):				
ecuted and transit		(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	f).				
'60, rate be executed ohysician and he burial - transi	Medical			Inf, G863, 1	/17/07 TT		van-	
(ecords, P.O. Box 6876). The law requires that the death certificate are has been signed by the attending phyage 2 should be detached for use as the 1	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregrit Live birth  4 Pregnant at time of de	2 Fetal deat		c pregnancy	23d. Date of delivery Month D	ay Year
). Bc: the dea by the a	Phys	1 Yes 2 No 9 Unknow  Part II. Other significant conditions	9 Unknown	esulting in the underlying	ng cause given in Pa	art I. 23e. Did to	bacco use contribute to t	he cause of death?
S, P.O. Boires that the de	ed by					1Yes	2 No 3 Prob	ably 4 Unknown
cords, law requir has been s	Completed					24a Was a autop perfor		opsy findings available ompletion of cause of
0 0 0		25. Was case referred to medical			26.Place of Death	1 V Yes		2 No
Vita hysician this cer	To Be	augmin a st	Hospital: 1 🗸 Inpatient 2	ER/Outpatient 3	DOA Other		Residence 6 Other:	
Division of Vital Records, rate or Attending Physician: The law requirer after death at Director: After this certificate has been stood in by the funeral director, page 2 should be		27. Manner of Death  1 Natural 5 Pending 2 Accident Investiga	28a. Date of Injury (Month, Day Year) Dec 6, 2006	28b. Time of Injury 0709 hrs	28c. Injury at Work 1 Yes 2 ✓	Subject shot	now injury occurred	
Division of Vital   Hospital or Attending Physician: 24 hours after death Funeral Director: After this certifitely filled in by the funeral director,	Certification:	2 Accident Investiga 3 Suicide 6 Could no determine	t be 28e. Place of Injury - At ho	ome, farm, street, factor	y, office building, etc	or Town, S	Street and Number or Runtate) Drive, Forestville, MD	al Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying Physic	cian: To the best of my knowledger: On the basis of examination are					
F > F 8	S S	29b. Signature and title of certifier	// /A	29	c License number		29d Date signed (Mon	th, Day, Year)
		Mana Dlasa	il (M.)	225)	O.C.M.E.		December 7, 200	6
207			completed cause of death (Item ssistant Medical Examin		treet, Baltimore	e, MD 21201		
	ate rar	31 Date filed (NDE Cay Yes) 20	06 3. Registrar's Signatu	facell o				
- logist	1	<del></del>	The state of the s	AND THE PARTY OF T				

			For State	State	of Ma	ryland / De				ealth a Death		•	- /	2006	39542	)
	4例1巻 ニ	(63.	Registrar  1. Decedent's Name (First, Middle	Last)			7011	mean	J OI L	Juan		2. Date of De	Reg. N6 ath	-000	3. Time of Death	
1	Physici		Leila		zabet	- h	Mal	Laug	hlia	n		Month December	Day	•		A M
١.,	/Medio		4a. Facility Name (If not institution			-11	MC			Location of		Decemb		. County of Dea		_
	EXAITIII	ier	Manor Care Ross					Ros	svil	le				Baltimo	re	
	Funeral		5. Social Security Number	6. Sex		(In yrs. last birth	day)_	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Dec. 9	th v. Year)	9. Bir	thplace (State or Forei	gn
1	Director		248 26 6288	1□ M 2√	F	89 Y	s.	WOTTERS	Days	110010		Dec. 9	,191	7 Sou	th Carolin	a_
	pu »		Usual Residence of Decedent  10a. State 10b. County			10c. City, Town	or Loc	ation							10d. Inside City Limit	ts
	Aaryli sho	ō	Maryland Baltim	020		Middle	D-i	TTOM							1 □Yes 2□N	ю
	18e-	rect	10e. Street and Number	ore		мтаате	KI	10f. Zip	Code				10g. Cit	tizen of What Co	ountry?	
	3a or	Funeral Director	5 Hydroplane Dr	ive					21	220				US	A	
	death	nera	11. Marital Status		Decedent 8 d Forces?	ver in U.S.	13. W	/as Deced	tent of His	spanic Ori	igin? (Spe	cify Yes or No Rican, etc.)	)-	14. Race - Ame Black, Whi		
9	4 within 72 hours after death with the Maryland jiene. r than "natural", or itame 23e or 28e-f ehow the Medical Ezandrat monthe Loutified at	/Fu	1 ☐ Never Married 2 🛣 Marr	ed 1 ☐ Y	es 200 N	0		☐ Yes		Specify:		1110011, 0101,		. 5"		
8	ural',	d by	3 Widowed 4 Divorced	Year	or Dates:	1 10- 5		4 - 11		A! = =			105 10	VV.	hite	
7-	"nat	Completed	15. Deceden (Specify only highes	t grade comple			Give k	ent's Usua and of wor ONOT us	rk done d	luring mos	t of worki	ng	160. K	ind of Business	rindustry	
12	filed within Hygiene. Sther then "	E G	Elementary/Secondary (0-12)	Colle	ge (1-4or 5 4	+)				Drive	ar		Pri	vate Bu	s Company	
D	Hyg Hyg Sthe ent,	BeC	17. Father's Name (First, Middle,	Last)			بيب		ous .			(First, Middle	, Maiden	Sumame)		
<u> a</u>		To B	Henry Weldon							Ar	mie	Wil	lson			
Maryland 21215-0036	and and sm	i ,	19a. Informant's Name/Relations	nip <i>(Type, Print)</i>	)	196. 1	Mailing	g Address	(Street a	ind Numbe	er or Rura	l Route Numb	er, City	or Town, State,	Zip Code)	
	s 1 and 2 if Health item 27		John W. McLaugh	lin (s	son)_	9 : 20b. Place of I				n Str		Middle		er, Mar	yland 2122	0_
Baltimore,	Se do L		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		rom State	cemetery,	crem	atory or o	ther place	1				,		
ij	it. Pa rtmer rtant njury		4 ☐ Ponation 5 ☐ Other (S		<	Bayview	7 Ci	remat	Ory	Inc	12/	12/06	Balt	imore,	Maryland Home PA	_
Ba	permit. Page Department important: If any injury or once.		21. 31911010 011 0.9131 3.910	3											nd 21221	
-8 - 5	-		23a. Par 1. Enter the disease, or shock, or heart failure. List	complications th	hat caused	the death. Do no								1241 / 144	Approximate Interval Between	
	Physician		Immedia e Cause (Final	only one cause	on sport in	عاطأه	1	Ja	A			440			Onset and Death	
10	/Medical		disease or condition resulting in death)	a. Du	e to (or as	a consequence of	):					.,				
	Examiner		Sequentially list conditions	b												
	of sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	e to (or as	a consequence of	):									
	and and 1-trans	Examiner	that initiated events resulting in death) Last	c	e to (or as	a consequence of	):									
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687	m ← =	adic		d												
Вох	eath certific attending p for use as f	N/W	IF FEMALE: 23b. Was decedent pregnant			of pregnancy	۰.	<b>-</b>						23d. Date of de	livery	
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2☐ No	4□P		2 Fetal death time of death		Ectopic pr Other (sp						Month	Day Year	
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a F												1 ☐ Yes	2 No		2 □ No	
Σ	Physicien: this certifica ral director, p	Be c	25. Was case referred to medica examiner?  1 ☐ Yes 2☐ No.	Hospital:	1 🗌 Inpatie	nt 2 ER/Out		200	Othe			(Check only		6 □Other (Spe		
0	g Phy er this eral d	٦: ا	27. Manner of Death	28a. C	Date of Injui Month, Day		me of		28c. Injury Work			28d. Describe			эсту)	
Ö	Attending I death. ctor: After y the funer	atio	1.□Natural 5 □ Pendir 2 □ Accident investi	9	моптп, Daj	rear) in	ury	М		r? Yes 2□	No					
Division	er des recto	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 288. F	Place of Injuding, etc	iry - At home, farr	n, stre	et, factory	, office			28f. Location ( City or To			ural Route Number,	
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	Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the funer	edicai		Examiner: On t		of my knowledge, examination and										
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Med	29b. Signature and title of certifie					290	. License	number			29d. Da	ite signed (Mon	th, Day, Year)	
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	ID		30. Name and address of person	who completed	cause of d	eath (Item 23a) (T	ype, F	Print)			0	_				
	10		Madai 1	O - 1- 1	~uk	,	S	Dal	cul	pool	Ko		12	100,	MY	
2.1	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC 1 2	2006	E. Hegistra	r's Signature	284	Es .								

State of Maryland / Department of Health and Mental Hygiene 39543 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec. D2006 Physician 10, 3:15 p Miller . Tnez Viola. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Larkin-Chase Nursing & Restorative Care Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗵 F 216-24-3968 80 Director 19, 1926 Dunkirk, Maryland Usual Residence of Decedent filed within 72 hours efter death with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours efter death with the Manyler Department of Health end Mental Hyglene.
Important: if Item 27 is marked other than "natural", or items 23a or 28a-f ahow any Injury or other traumatic event, tra Medical Examiner must be notified at pice. 1 ☐ Yes 2 No Directo Prince George's Maryland Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6003 Quintana Street Funeral 20737 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify. Specify: White ڄ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry University of Elementary/Secondary (0-12) College (1-4or 5+) Administrative Secretary Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clinton Trott Elsie Wedington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daryl M. Miller - Son 6003 Quintana St., Riverdale, MD 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 12/14/06 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 21. Signature of Funeral Service Lice see 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part : Etter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Congestive heart failure Examiner Due to (or as a consequence of) Examiner Atrial fibrillation or Attending Physician: The lew requires that the death certificate be executed the buriel-trensil Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Sepsis ģ 8 cete hes been sig , pege 2 should b 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Gangrene foot 1 Tyes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 28 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. I Director: A bd in by the fr 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter of To the Funeral Direct completely filled in by 4 Homicide To the Hospital 1EX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D43351 12/11/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ikechi Fred Okwara 6201 Greenbelt Rd, Ste U-15, College Park, MD 20740 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

DEC 1 2 2006

lai.			1 - For State Registrar	State of Maryla		artment rtificate			nd Menta		ene	06	39544
	Physic	de lan	1. Decedent's Name (First, Middle, Las	t)						te of Death	Day	V	3. Time of Death
	/Medi		RICHARD ANDREW	MOUSSEAU							er 9,	2006	10:45 a M
	Exami	ner	4a. Facility Name (If not institution, give	street and number)		4b. City,	own, or	Location of	Death		4c. County	of Death	
	<b>3</b> 6		6220 Seminole					Heig			Prin		eorge's
	Funeral Director		5. Social Security Number 6. Sec. 577–16–8967  Usual Residence of Decedent	M 2□F 85	. last birthday) Yrs.	If Under Months		If Under 24 Hours	Min. Fel	te of Birth onth, Day, )	1921	9. Birthp Cour Sout	place (State or Foreign htry) Ch Carolina
re, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. I'm Medical Exartinal must be notified at ONCE.	To Be Completed by Funeral Director	10a. State 10b. County  Maryland Prince  10e. Street and Number  6220 Seminole Pl.  11. Marital Status  1 Never Married 2 Marned  3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grace)  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last)  Henry Rockwell  19a. Informant's Name/Relationship (T. Leslie M. Jacoby  20a. Method of Disposition	George's  ace  12. Was Decedent Ever in the Armed Forces?  1 Mayes 2 \( \subseteq \) No Hyes, Give Year or Dates:  1 cation te completed)  College (1-4or 5+)  Mousseau  1 ppe, Print)  Daughter  20b.	II 16a. Dece Give life. Mass	Heigh  10f. Zip  2  Was Decedder If Yes, specific Yes, spe	O740 ent of His y Cubar No Occupa c done de retired)  Street au	spanic Origin, Mexican, Specify: tion uring most co er  18. Mother's He and Number to Road	n? (Specify Ye Puerto Rican, of working s Name (First, nrietta or Rural Route , Hagel Date	Middle, Ma  A Schi  Number, C	Specify Specify Cafr Cafr iden Suman	What Cour A.  Be - Americ ck, White,  Wh  Itz  Be  State, Zip  21742	can Indian, etc.  ite  dustry
Baltimore,	permit. Pages Department of Important: If i any injury or once.		1 ⊠ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licens	Dasch Lat	dar Hill	Cemet Name and 739 B	ery <sup>Address</sup> alti	12 s of Facility more	(/14/20 Gasch Avenue	06 s Fur Hyat	Suitla neral l tsvil	nd, M	Maryland
8760,	Physician Medical Examiner  the private and physician and physician and physician and physician and physician are physician and physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician and	Ical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Terminal  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)	Cancer quence of):				rdiac or respin	atory arresi			Approximate Interval Between Onset and Death 4 Months
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. within 24 hours after death. completely filled Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3	Ectopic pred Other <i>(spec</i>					23d. Date Mor	e of delive	ry Day Year
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al Reco	ding Physician: The law re. h. After this certificate has bee funeral director, page 2 sho	Completed	Hyperlipemia, Pr	ostate Cancer						autopsy performed Yes 2X	d? d	Vere autoprior to coneath?	osy findings available inpletion of cause of 2 No
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o	Phys this ral dir	2	1 ☐ Yes 2 ☒ No ☐ ☐ 27. Manner of Death	1 Inpatient 2	ER/Outpatient 28b. Time of		Other	4 🗌 Nursı	ng Home 5∑	Residenc	e 6 □Othe	r (Specify	)
Division of Vital Records,	ul or Attending after death. Director: After d in by the fune	Certification:	1 🕅 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At h building, etc. (Specif	Injury ome, farm, stre	М		es 2 No	28f. Loc		injury occurre t and Number tate)		Route Number,
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)	To t within	×	29b. Signature and title of certifier  Signature and title of certifier  30. Name and address of person who co	mpleted cause of death (Item	n 23a) (Type, F			339	chien,		Date signed	(Month, C	
Total Services	Sta Registr		8824 Cunningham D 31. Date filed (Month, Day, Year) DEC 1 2 20		wyn Hei								

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39545 Reg. N2 UU6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>006</u> Month Physician James N. Moore Sr. 1:15 P M Dec. 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1232 Seven Oaks Road Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months 1 XM 2 ☐ F Days Hours Min. 79 **Director** 215-22-5661 March 12,1927 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d other than "natural", or items 23a or event, the Medical Examiner must be 1232 Seven Oaks Rd 21227 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Affiled Folices. 1 XYes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 Married 1 ☐ Yes 2 📉 No þ Specify. Specify: White 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Snacks 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Moore ပ Dorothy Lauman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Moore/Wife 1232 Seven Oaks Rd Halethorpe, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 12/15/06 Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Rd Catonsville, MD 21228 23a. Part1. Enter the disease, or co plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List opy one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2 wells /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a detached f 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼ No 24a. Was an autopsy certificate 2**X**No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🔲 Yes 217 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital or within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

P.O. Box 68760,

Division or Vital Records,

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

DEC 1 Registra

29b. Signature and title of certifier

OCO

FREDERILL ROAD mgistrar's Signaturé

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUPTE

**ORIGINAL** 

29c. License number

SA

LYLMORE

29d. Date signed (Month, Day, Year) December 11, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMIND ITEM#2. perPHYS. G863.1/9/07 WS.
State of Maryland Department of Health and Mental Hygierre 19a, perInf. Continues of Postth 39546 Amend #19a,perInf, 1 - For A State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MUNCK Month Da **Physician** 700PM December 6 erett 2006 /Medical 4a. Facility Name (If not institution, give street and number Examiner NAPOUS MEDICAL ( Year If Under 24 Hrs. Birthplace (State or Foreign Country) Sex 1X M 2□F Social Security Number **Funeral** Months Hours Director 216-34-1624 70 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show or items 23a or 28a-f show MD Queen Anne's Stevensville 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WIT 137 Olive Branch Road 21666 <u>United States</u> 12. Was Decedent Ever in U.S. Amed Forces?

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1056 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. be filed within 72 hours after 1X Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ◯XNo Specify: Specify: traumatic event, the Mudical Exa-White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Ornamental Iron al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Company 12 Iron Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Everett L. Munck, Sr. Helen Miller ျှ 19a. Informant's Name/Relationship (Type, Print)
Loraine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 137 Olive Branch Road, Stevensville, MD 21666 Item 27 other tra <del>loriane</del> M. White - Sister 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens Date 20c. Location - City or Town, State 20a, Method of Disposition Department of H Important: If Ite any injury or ot once. Rurial 2 Cremation 3 Removal from State 12-9-2006 Donation 5 Other (Specify) Timonium, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Lice 2719 Hanmonds Fry Rd., Lansdowne, MD 21227 23a. Part 1. Enter the disea or complications that a sed the deat. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final 50PS15 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner URINARY TRACT IN FECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ page 2 should be OBSTELCTIVE PLLMONDRY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed MARIGNSONS 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate 2 No 1 Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2. No 2 P/Outpatient 3 DOA this After this funeral d 28a. Date of Injury (Month, Day Year) 27. Many of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: Al M 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 860/ Verepans HIGHWAY Muersville MD 21108
rs Signature 30. Name a address of person who completed cause of death (Item 23a) (Type, Print) ANKROW MO 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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			Registrar  1. Decedent's Name (First, Middle, Last)			imouto or D	Julii	2. Date of Death	g. No. U		3. Time of Death
	ysicia		Major W. McNabb					Month 12/06/2	Day 2006	Year	09:40A M
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	neral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 04/10/1	Year)	9. Birthp Coun	lace (State or Foreign try)
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ath w	usti		7575 E. Howard Road			21060			U.S.A		
er de Itams	Jan .	Funeral	Tr. Manual States	Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of Hisp f Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)		ce - Americ ck, White,	
1215-0036 within 72 hours after death with the Maryland ene.	T. C.	by F		1 ⊠ Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2⊠ No	Specify:		Specif	y: wh	ite
Maryland 21215-0036 td 2 should be filed within 72 hours aff lth and Mental Hygiene. 27 is marked other than "natural", or	Cal	ted	15. Decedent's Education (Specify only highest grade co			dent's Usual Occupation		10	6b. Kind of B	usiness/Ind	lustry
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			1 - Fo <b>Amend #5 Per Ir</b> 1 - State Registrar	£t <b>ete</b> 62 M	27/137	06 DMP a	artmen tificat	t of H e of L	ealth a	and Me		giene Reg. No.	006	395	548
			Decedent's Name (First, Middle, Last,								2. Date of Dea			3. Time of	Death
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	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location o	of Death			County of Dea	ath	
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и	Director		587-70-7 <del>771</del>	]M 2₫F	62	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month Day May 1,	1944	· Cǐ	iile	
	<u> </u>		Usual Residence of Decedent												
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	25		30. Name and address of person who co	moleted cause of d	leath (Item	23a) (Tune	Print)				1	-			
	<i></i>		David Cosgrove, M.	D. 401 I	North	Broad	lway,		imor	e, Ma	ry1and	212	231		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4:42 A M December 10, 2006 Catherine Gill Marth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🛛 F Months Days Hours 6, Massachusetts 577-32-7272 Director 81 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland | Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 14421 Traville Garden Circle 20850 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. ۾ 3 Widowed 4 Divorced White Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Francis Gill Mary Drohan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard M. Marth/ Son 4904 Bel Pre Road, Rockville, Maryland 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Rockville Cemetery 4 ☐ Donation 5 ☐ Other (Specific Dec. 13, 2006 Rockville, Maryland 21. Signature of Funeral Service Robert A. Pumphrey Funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** weeks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical the 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 INO To the Hospital or Attending Physician. within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient ဥ 2 ER/Outpatient 3 DOA 27. Mannet of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and 10% of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 10, 2006 30. Name and address of person who completed cause of death (Item 23a) Russell Ave. MD Steven Wolinst 31. Date filed (Month, Day, Year) 2. Registrar's Signature State DEC 1 2 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 10, 2006 **Physician** JOAN M. MERTZ 5:00 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE TIMONIUM BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, Year) | 10/14/1937 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 TF Yrs. Director 212-34-5685 69 NEW YORK Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits Director MD BALTIMORE TOWSON 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 ONE SMETON PLACE 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No þ WHITE Specify. 3 ☐ Widowed 4 ☐ ivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RETAIL 12TH GRADE SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RAGNER HAGER SIGRID C. JACKSON 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONALD E. MERTZ, JR./SON 1552 DOXBURY ROAD TOWSON, MD 21286 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 € Burial 2 Cremation 3 Removal from State 12/14/2006 PARKWOOD CEMETERY BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Marga and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each live. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** RENAL CELL CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2**X** No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No HOSPICE 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attenuers within 24 hours after death.
To the Funeral Director: Aft 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 437 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

DR. TARIO MAHMOOD

DEC 1 2 2006

31. Date filed (Month, Day, Year)

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 39551 State of Maryland / Department of Health and Mental Hygien $oldsymbol{\epsilon}$ .  $\cup$   $\cup$   $\cup$ Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year MACK DECEMBER 8, BEATRICE 2006 12:36 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1□M 2☑F Yrs. 135-18-6937 85 12/14/1920 NJ Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐Yes 2 ☐ No MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1801 E. JEFFERSON STREET 20852 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 2 Elementary/Secondary (0-12) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) GOODMAN JENNIE ORLIKOFF 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S. KENNETH MACK / HUSBAND 1801 E. JEFFERSON STREET - ROCKVILLE, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State BETH EL CEMETERY 12/11/2006 PARAMUS, NJ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., Marle Cer 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition PNEUMONIA 2 WEEKS resulting in death) Due to (or as a consequence of) ate of delivery Aonth. Day Year

Priysician /Medical For State Registrar

10a. State

**Physician** 

/Medical

Examiner

**Funeral** 

Director

s 23a or 28e-f show

or Items

permit. Pages 1 and 2 should be filed within 72 hours after dei Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items any injury or other treumatic event, tre Medical Examiner Pages.

Baltimore, Maryland 21215-0036

Director

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Completed

Be

**JACOB** 

death with the Maryland

Examiner

use as the burial-transit attending physician and

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The law requires that the death certificate be executed

To the Hospitel or Attending Physicien:

after death.

24 hours

within 2

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completely filled in by the funeral director,

Division of Vital Records, P.O. Box 68760,

Completed by Physician/Medical Examiner Certification; To Be Medical

29a. Certifier

Sequentially ist conditions, if any, leading to immediate cause. Enter Underlying Cause (classes or injury) that initiated events resulting in death) Last	Due to (or as a consect of the conse				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 ⊟Ectopic preg			23d. Date of delivery Month Day Year
Part II. Other significent conditions of RENAL FA	•	sulting in the underlying cau	se given in Part I.	23e. Did tobacco i	use contribute to the cause of death? XNo 3□ Probably 4 □Unkno
ANEMIA				24a. Was an autopsy	24b. Were autopsy findings availa prior to completion of cause
ATRIAL FI	BRILLATION			performed? 1 ☐ Yes 2 🗓 No	death?
25. Was case referred to medical			26. Place of Dea	ath (Check only one)	
examiner? 1 □ Yes 2 💢 No	Hospital: 1 X Inpatient 2 ☐	☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing H	dome 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of 28d Injury M	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred
3 Suicide 6 Could not be	28e. Place of Injury - At h	office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number,	

building, etc. (Specify)

City or Town, State) 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

29b. Signature

29c. License number

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) DEVEMBER 8, 2006

3 Probably 4 Unknown

Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901 MEDICAL CENTER DRIVE - ROCKVILLE, MD 20850

D0060117

State Registrar 31. Date filed (Month, Day, Year) DEC 1 2 2006



			for Stete Registrar	State of Marylan	d / Depa		ealth and		9	6 39552
	Physici /Medic		1. Decedent's Name (First, Middle, Last	MEL	NIC			2. Date of Death	7°09'2	3. Time of Death 606 4:50 p. M
	Examir	er	4a. Facility Name (If not institution, give NORTHWEST HOSPITA			4b. City, Town, or RANDALL		ith	4c. County of	
	Funeral Director		5. Social Security Number 6. Se 214-01-1024	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		<b>191</b> 7	9. Birthplace (State or Foreign Country) MD
	aryland	_	Usual Residence of Decedent  10a. State 10b. County		y, Town or Lo		NUTNOS M	TLLC		10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	or 28a-f	Funeral Director	MD BALTIMO	IKE	7 14.7	10f. Zip Code	OWINGS M		og. Cilizen of Wh	nat Country?
	ne 23a	eral	10 WINNER CIRCLE	12. Was Decedent Ever in U	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	21117	Specify Yes or No-	14. Race	USA - American Indian,
9000	rours after or trer	٥	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:			n, Mexican, Pue	rto Rican, etc.)	Black,	White, etc. WHITE
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. do other then "naturel", or Items 23a or 28a-f ehow event, I're Medical Examinar must be notified at	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Dece (Give life. OWNE	dent's Usual Occupi kind of work done o DO NOT use retired	ation furing most of w	orking	16b. Kind of Bus	iness/Industry
yland;	s should be filed withir and Mental Hygiene. Is marked other then sumatic event, the M	To Be C	17. Falher's Name (First, Middle, Last) FRANK		СОНЕ	EN	18. Molher's Na LENA	ame (First, Middle, M	faiden Sumame,	KESSLER
	2 4 5 5		19a. Informant's Name/Relationship (T) RENA SUE SHERMAN					Rural Route Number, BALTIM		tate, Zip Code) 21208
Baltimore,			20a. Method of Disposition 1 ∭ Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,	20b. F	cemetery, crei	osition (Name of matory or other place CHIZUK A		15		ity or Town, State
Baltin	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licens		23	2. Name and Addres	s of Facility	OL LEVINS	ON & BRO	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	ications that caused the deat		er the mode of dyin	g, such as cardi			Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq	uence of):	DEMIC	SNT/A			
H		liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	ueliče čl):					
,092	eath certificate be executed attending physicien and for use as the burial-transit	cal Examiner	resulting in death) Last	Due to (or as a conseq	uence of):					
P.O. Box 68	The law requires that the death certificate be executed sie has been signed by the attending physicien and cage 2 should be deteched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1□ ₩6 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at lime of d 9 □ Unknown	Ideath 3	Ectopic pregnancy			23d. Date Monti	
	quires that in signed build be dett		Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I. Mer -			ute lo the cause of dealh?
Il Records,		Completed by	Tengion			(	<u></u>	24a. Was ar autopsy perform 1 Yes 2	pri ned? de	ere autopsy findings available or to completion of cause of ath?  ☐ Yes 2 ☐ No
Vital	Physicien: this certifice ral director.	Be	25. Was case referred to medical examiner?	lospital: 1 Impatient 2	FR/0-4	Othe	200	eath (Check only one		
of	P this	tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injun	4 □ Nuising	Home 5 Reside		
Division	To the Hospital or Attending within 24 hours effector: Atter To the Funeral Director: Attercompletely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	reet, factory, office		28f. Location (Str City or Town		or Rural Route Number,
	Hospita 124 hours Funera Hetely fille	Medical C	29a. Certifying Phy (Check only one)	sicien: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occ	e, and due to the ca curred at the time, da	use(s) and manr te and place, an	ner as stated. d due to the cause(s)
)	To the To the complete	M	29b. Signature and title of certifier	ngarajan	M	29c. License	5428	8	Decem	Month, Day, Your 2006
	6		30. Name and address of person who c	ompleted cause of death (Item	n 23a) (Type,	Print) a / C	juty iv	est Hus	pital	Center
	Sta Registi		31. Date filed (Month, Day, Year) DFC 1 2 2	32. Riegistrar's Signa	ature	partie				

			For State Registrar		State	of Maryla				lealth and Death	Mental H	ygiene Reg. No.		39553
A.	2		1. Decedent's Name	(First, Middle	, Last)						2. Date of D		Year	3. Time of Death
	Physici /Medic		Phillip E.	Neary							Dec 10			1:05P M
	Examir	er	4a. Facility Name (If	not institution	give street and n	umber)				Location of Deat	h		County of Dea	
	<u> </u>	-	304 Packar 5. Social Security No.		6. Sex	7 Ann (In ves	a. last birthday)		ndale r 1 Year	If Under 24 Hrs	8. Date of B	irth	ne Arund	
	Funeral Director				1 <b>K</b> XM 2□F	71	Yrs.	Months		Hours Min.		1935	C	rthplace (State or Foreign ountry) MD
ت			219-26-217 Usual Residence of	73 Decedent										
	how		10a. State	10b. County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	Ba-1-e	cto	MD	Anne Art	undel	Fe	rndale							1 Tes 2 No
	ih th or 24	Funeral Director	10e. Street and Nun	nber				10f. Z	p Code			10g. Citi	zen of What C	country?
	ath w	rai	304 Packar	d Ave	10.111-10-		11.5		1061	ii- Osiaia2 (6	Spoody Von av h		USA 14. Race - Am	encan Indian
	er de	une	11. Marital Status 1 ☐ Never Marrie	od XX Marci	Armed F	cedent Ever in Forces? 2 KNo	U.S. 13.	Yas Deci	ecify Cuba	ispanic Origin? (S In, Mexican, Puer	to Rican, etc.)	10-	Black, Wh	
36	if, or	by	3 Widowed		If Yes, G Year or	ive		1 🗌 Yes	2 🔀 <b>N</b> o	Specify:			Specify: Wh	ite
21215-0036	d within 72 hours after death with the Maryland jiene. r then "natural", or iteme 23a or 28a-f ehow the Madical Exeminar must be natified at			15. Decedent			16a. Dece	dent's Us	uaf Occupa	ation	elem e	16b. Ki	nd of Business	s/Industry
215	c * m	ple	(Speci Elementary/Secon		t grade completed	(1-4or 5+)	life.	DO NOT	use retired	·	rking			
	filed within I Hygiene. other then	Completed	12		10		Ber	efits	Manag				eneral M	lotors
pu		Be	17. Father's Name (	First, Middle, I	_ast)					18. Mother's Na.		e, Maiden	Sumame)	
yla	ould Men varke	မ	Thomas Fra				405 14-10		(0)	Edna Mae		has City	- Taura State	Zin Code)
Maryland	12 sh h and 7 is m		19a. Informant's Na							and Number or R			r rown, State,	Zip Code)
e,	1 and Heelt em 2		Alice Near		Wife	20b.	Place of Disno	sition (Na	ame of	, Ferndale	, MD 210 Date	_	cation - City o	r Town, State
õ	ages int of t: If it / or o			Cremation	3 □Removal from	n State M	cemetery, crer eadowridg	natory or je/Cen	other plac letery	Dec 1	4, 2006	Elkr	idge, MD	)
Baltimore,	ertme ortan injur		21. Signature of Fu							ss of Facility		1		
B	permit. Pages 1 and 2 should be Deperfurent of Heelth and Menta Important: If item 27 is marked any injury or other traumatic en ODE.		R. Greg	ory FXn	k NO	01148				l Home, P. vy S. Glen		i4D 21	061	
			23a. Part1. Enter the shock, or hear	e disease, of	complications that	caused the de								Approximate Interval Between
	Physician		Immediate Cause (	Final	3,m, 3.m2, 3.00 3.m	narly	insoris	de	nas	0				Onset and Death
	/Medical		resulting in death)		Due to	(or as a conse		0-1	7					
	Examiner		Sequentially list con	nditions.	b									
- Q.	E 18	Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i	mediate rlying	Due to	o (or as a conse	equence of):							
	and and Ftrans	xam	that initiated events resulting in death) L		c	o (or as a conse	equence of):							
68760,	ficate be executed physician and is the burial-transit	E III				`	,							
687	ficate physics the	edicai			d									
Box (	eath certifi attending	Z/M	IF FEMALE: 23b. Was decedent	pregnant		utcome of preg		7					23d. Date of de	efivery
	death e atte	icia	in the past 12	months?	4□Pre	birth 2 ∏Fe gnant at time of		Other (	pregnancy specify)				Month	Day Year
P.0	by the de	Physician/M	9 Unknown		9□ Unk	nown								
	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	by	Part If, Other signifi	A /		death but not re	esulting in the u	nderlying	cause give	en in Part I.				to the cause of death?
Records,	w require been si should i	ted		Lovig	· man					<del> </del>	1	1 Yes 21		Tobably 4 Dorkhown
ec	has by	Completed										s an opsy formed?	24b. Were a prior to death?	autopsy findings available completion of cause of
H	: The l	Co									1 ☐ Yes			s 2 No
Vital	ician: Th certificate rector, pag	Be	25. Was case referr	,	Hospital: 4 F				Othi	26. Place of De	11			
of	shys this aldi	2 1	1 ☐ Yes 2 ☐ 27. Manner of Death			Inpatient 21	ER/Outpatier 28b. Time o		NA	4 🗀 Nulsing i	lome 5 Re 28d. Describe		6 Other (Spi	ecify)
	ine ite	tion	1 Natural	5 Pendin	g (Mo	onth, Day Year)	Injury	м	28c. Injun Work	k?¨ Yes 2 ⊡No			,	
Division	l or Attending effer death. Director: After	fica	2 Accident 3 Suicide	6 Could r	not be 28e. Pla	ce of Injury - At	home, farm, sti	eet, facto	ry, office					Rural Route Number,
Ö	el or setter	Certification:	4 🗍 Homicide		buil	ding, etc. (Spec	cify)				City or 1	own, State	,	
	To the Hospital or A within 24 hours efter To the Funeral Director Completely filled in b.		29a. Certifier (Check only		g Physicien: To the Exeminer: On the									
	the H in 24 the F nplete	Medical	one)	1.1.	and ma	inner stated.		-						
	with To	Σ	29b. Signature and	titte of certifie	1 Maria	MAN	7	2	ou. LICHTS	DUII (/A	U	zau. Dai	te signed (Mor	1 d1_
	3			uu	101100		02-\ /T	Drict)		1780	7	' /	4116	, e
	6		30. Name and addre	n M	WIND COMPLETED CA	D SU	28 Kitc	life	Hun	1 Frite 1	34 Pa	sad	ena M	nth, Day, Year)  106  21/22
1	Si Si	ate	31. Date filed (Mont	th, Day, Year)	32	Registrar's Sig	nature				-			
I Deli	Regist		DE	1 0 2	noc L.		4							

06-09344 Gary Nejus

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		ate of Death	Reg. No.	0000
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)  OHN WETUS		2. Date of Death Month Day Year December 7, 2006	3 Time of Death U 1509 hrs
and the second	4a. Facility Name (if not institution, give street and number) 7400 North Point Road	4b. City, Town, or Location of Death Sparrows Point	4c. County of Death Baltimore Cou	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last bir 2/2 - 44 - 2242 1 2/2 F 6. Sex Usual Residence of Decedent	thday) If Under 1 Year If Under 24Hrs Months Days Hours Mir	s. 8. Date of Birth (MM/DD/YYYY) 9. Bird Foreig	thplace (State or
and show any nace	10a. State 10b. County 10c. City, Town	or Location	. / /	10d. Inside City Limits 1 Yes 2 1 No
· death with the Maryland or items 23a or 28a-f sho must be notified at once Funeral Director	10e. Street and Number  7302 BAVF RONT RD.  11. Marital Status  12. Was Decedent Ever in U.S.	/ 10f. Zip Code 2/2/9	10g Citizen of What Cour	A ·
s after death with rral", or items 23 niner must be no by Funeral	11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in U.S.  Armod Forces?  1 Yes 2 No  13 Widowed 4 Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? ( Sign Yes, specify Cuban, Mexican, Puerto     Yes 2 No specify:		can Indian, Black,
5-0036 6-within 72 hours stygiene. other than "naturs he.Medical Exami	<ol> <li>Decedent's Education (Specify only highest grade completed)</li> <li>16a.</li> </ol>	Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use reti	work done 16b. Kind of Business/li	ndustry
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)  GERHARD  WEJUS	MECH- 18.Mother's Name EM 1	e (First, Middle, Maiden Surname)	Λ
ore, MD 21 st and 2 should of Health and Me If item 27 is ma her traumatic ev	EDWIN NETUS	b. Mailing Address (Street and Number or I	Rural Route Number, City or Town, State,  Date 20c, Location - City or	Zip Code) 2, 903
		ory or other place)  () EW CREM.  22 Name and Address of Facility	-11-06 BALTO.	, HD
Balt Balt Depart Import Import	23a. Part I. Enter the disease of r complications that caused the death. Do not	SKARDA FH.	BALTO ILL 20 or respiratory arred, shock, or heart	274 Approximate Interval
/Medical Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a Hypertensive atherogous for condition resulting in death)  Due to (or as a consequence of):	sclerotic cardiovascular	disease	Between Onset and Death
ted msit <b>Examiner</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated control of the control of the cause of			
recuted I and I transit	events resulting in death) Last  Due to (or as a consequence of):  d.			
760, icate be executed by the burial - tra	IF FEMALE: 23c. If yes, outcome of pregnancy	E, g863, 1/10/07 TT	23d. Date of delivery	
D. Box 68: the death certiff by the attending sched for use as in	23b. Was decedent pregnant in the past 12 months?  1	=	ancy Month D	ay <b>Y</b> ear
S, P.O. B uires that the d n signed by the Id be detached ed by Phy	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco use contribute to to	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death the Physician: The law requires that the death certificate by the attending physician and completely filled in by the thineral director, page 2 should be detached for use as the burial - transfered Certification: To Be Completed by Physician/Medical E	· · · · · · · · · · · · · · · · · · ·			opsy findings available on photosic formulation of cause of the second sec
Vital Reconstituted by sician: The this certificate I director, page To Be Con	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Out	26.Place of Death (Check of utpatient 3 DOA Other Nursin	only one)  g Home 5 Residence 6 ✔ Other:	Soone
ion of Virenting Physicath or: After this the funeral direction: To	Tes 2 No	Time of Injury 28c. Injury at Work?  1 Yes 2 No	28d Describe how injury occurred	Ocene
Division o ospital or Attending hours after death or meral Director: After the pit filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify)	rm, street, factory, office building, etc.	28f. Location (Street and Number or Run or Town, State)	
To the Ho within 24 h To the Fui completely	(Check only one) 2 Certifying Physician: 10 the best of my knowledge, dea one) 2 Medical Examiner: On the basis of examination and/or in and manner stated			
Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Moni	
	30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examine			
State Registrar	31. Date filed (MS) E (My) Year) 2806 32. egistrar's Signature	Aus		

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Loretta Wandalene Nevin December 6,2006 12;05 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 158 Ryan Road Pasadena Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | OCt. 27, 1933 9. Birthplace (State or Foreign Country) VA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F 214-26-7297 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 4th Avenue SW 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify Specify: ò 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Pauley Lula Owens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Samuel R. Nevin/Husband 305 4th Avenue SW Glen Burnie, MD21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 2006 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. MOJUTA 1 Second Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) (ancer **Physician** 449 Due to (or a a consequence of): /Medical Examiner 2 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner physician and street street The law requires that the death certificate be executed Due to (or as a consequence of): attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) signed by the a Id be detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Daughter Hospital: Other:  $_{4\square \text{ Nursing Home}}$  5  $\square$  Residence 6  $\square \text{Other}$  (Specify) Residence1 🗀 Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 027938 ano Name and address of person who completed cause of death (Item 23a) (Type, Print) Agrichat Rd. Glen Brine and 2106 Maye, 00 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar

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:45

DECEMBER 10

Box 68760.

Records, P.O.

Division of Vital

NOPPENBERGEF

FLORENCE

2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 2006

22. Registrar's Signature

EDDIE NAKHUDA,

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 006

39557

					Certific	ate of I	Death		Reg. i	No.		
		1. Decedent's Name (First, Middle,						2. Dat	e of Deeth	Dey	Yeer	3. Time of Death
	Physician /Medical	SOPHIE 1	DLSzev	NSK 1				13			06	Pm
	Examiner	4a Fecility Name (If not institution,	give street end number)			4	b. City, Town	n, or Location of		4c. County	of Death	
7	Examiner	Future Care 01	d Court				Randa	11stown		Ва	ltim	ore
	Funeral			e (In yrs. lest birt		nder 1 Year	If Under 24	Hrs. 8 Date	e of Birth	1		ace (State or Foreign
	Director	213-34-0779	1 □ M 2 🔀 F	92	rrs. Mon	ths Days	Hours	Octobe	nth, Day, Ye			ryland
	4	Usuel Residence of Decedent		92			L	OCLOBE	1 309	1714	LACE	Lyrami
3	E 8 ≡	10e. Stete 10b. County		10c. City, Town	or Location						10	Od. Inside City Limits
9		Maryland Balt	imore	Randa	allsto	wn						1 ☐ Yes 2 No
4	or 28e-1 s be notified Director	10e. Street end Number			10f	. Zip Code			10a (	Citizen of W	/hat Count	try?
4					101							
4	r items 23 dinar must Funeral	5412 01d Court		Francis II C	40 Mar D	21133		-0 /Cif V-			- America	of America
Ť		11. Maritel Status	12. Was Decedent E Armed Forces?		If Yes,	specify Cube	n, Mexicen, F	n? (Specify Ye Puerto Rican, e	etc.)		k, White, e	
ನ ಕ	by F	1 Never Merried 2 Marrie	If Yes, Give	No	1□ Ye	s 21 No	Specify:			Specity:	Wh:	ite
Maryland 21215-0020	"natural", or items 23e or 28e-f show adical Examiner must be notified at leted by Funeral Director	3 Widowed 4 Divorced	Year or Dates:						401	10 1 15		
5	ygiene. ygiene. tr. ma Medical E	15. Decedent's (Specify only highest)		16a.	Give kind of	Jsual Occupa work done o	ation during most o I)	of working	166.	. Kind of Bu	siness/ind	ustry
2	9 6	Elementary/Secondary (0-12)	College (1-4or 5	i+)								
d 2	Ser S	3	0	ļ	Home	Maker				Own H		
Pu 5	Se Se Se Se Se Se Se Se Se Se Se Se Se S	17. Father's Name (First, Middle, La	st)				18. Mother's	s Name (First,	Middle, Maid	len Sumame	∌ <i>)</i>	
yla	Mantel H Marked ott atic even	Unknown					Unknov	wn				
a a	and lead	19a. Informant's Name/Relationship			_			or Rural Route	-	-		
Ž į	27 in tra	Bridget C. Beres	Guardia	ınship) l	Dept A	ging,	611 C	entral	Avenue	, Tow	son,	MD. 21204
ē. 5	E E	20e. Method of Disposition		20b. Place of	Disposition (	Name of or other place	۵)	Date	20c.	Location - 0	City or Tov	vn, State
imor	y or if	1 ☐ Burial 2	Removal from State	Metro				12/09	/06Cat	onewi	110	MD. 21228
Baltimore,	: 원란 등 .	21. Signature of Funeral Service Li		necto	1	and Addres		12/07	, oocat	CHOV	ile,	HD. ZIZZO
Ba	mpo any i		00		ZZ. IVGIII	3 4114 7 144100	o or r domey	Loring	Byers	s Fune	ral I	Directors
		DOOLY KO		0333						own,	Mary.	Land 21133
	_	23a. Part . Enter the disease, or co shock, or heart failure. List or	inplications that caused by one cause on each lir	the death. Do n	ot enter the r	node of dying	g, such as ca	rdiac or respira	atory arrest,			Approximate Interval Between
P	hysician	57										Onset and Death
	/Medical	Immediate Cause (Final disease or condition	EN	0 5	STAC	ic	13	Em E	NTI	4.	1	
- E	xaminer	resulting in death)	a. EN	Due to (or es e c	onsequence	of):					1	
	ē _		ALT	2 HEI	n En	LS	ma	SCAS	56			
ox 68760, certificate be executed	dding physician and use as the burial-transit	Sequentially list conditions.	D	Due to (or as e c							1	
oʻ å	EX Talt	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying									i	
68760,	ysici e bu	that initiated events	C	Due to (or as a co	onsequence	of):						
89	as th	resulting in death) Last			111						i	
			■ d								<del>- i</del>	
<b>m</b> $\frac{1}{2}$	been signed by the etter should be detached for u	Part II. Other significant conditions		it and annuiting in	the underlying		n in Dari I	001	Did toboo	00 1100 000	eributo to	tha cause of death?
o g	y the		-	1	ine underlyii	ig cause give	minrani.	230				
ם ב	deta deta	MAZ	NUTRI	7100					1 🗌 Yes	219/NO	3   Probe	ably 4 Unknown
DIVISION of Vital Records, P.O. or Attending Physician: The law requires that the da	cate has been signed, page 2 should be d	_		_				240	. Was an au	toney	24h Wei	e autopsy findings
0	houl houl	13	EHYBRA	1100				2.40	performed?		avai	lable prior to
<u>s</u>	୍ଷ୍ୟ ପ୍ର							_			of de	pletion of cause eath?
<u> </u>	page Page		ANEM	1 PF					1 Ves	3 No	1 🗆	Yes 2. ₩o
E E	ertifica ector, Be	25. Was case referred to medical					26. Place of	Death (Check	only one)			
<u> </u>	his ce Il direc	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatier	nt 2 ER/Out	patient 3	DOA Othe	r: 4 Nursi	ing Home 5	Residence	6 □Othe	r (Specify)	
0 5	era c	27. Menner of Death	28e. Dete of Injun (Month, Day			28c. Injury Work			cribe how in			
0 \$	atio	1 ☑Naturel 5 ☐ Pending 2 ☐ Accident investigat		(1041)	jury M		res 2□No					
	after deal Director: I in by the ertifica	3 ☐ Suicide 6 ☐ Could not	200. Piece oi inju	ıry - At home, farı	m, street, fac	tory, office					r or Rural	Route Number,
5 8	북동 등	4 ☐ Homicide	building, etc.	. (Specity)				City	or Town, Sta	are)		
To the Hospital	within 24 hours after death.  To the Funeral Director: After this certificate ha completaly filled in by the funeral director, paga  Medical Certification: To Be Com	29a. Certifier 1 Certifying I	Physician: To the best of	f my knowledge.	death occurr	ed at the tim	e. date end n	place, end due	to the cause	(s) and man	ner as sta	ited.
Š	Prur etaly		aminer: On the basis of and manner stet	examination end								
off c	Me the	29b. Signature end title of certifier			1	29c. License	number		29d. D	Date signed	(Month, D	ay, Year)
ř	≯ <b>⊢</b> 8		- 0	Δ.		A -	20	11100	2 .	0		
		100	12 /c.		1-12	NC.	000	175	11	D- (	210	- 06
		30. Neme end address of person wh	طاه	eath (Item 23a) (T	ype, Print)	l inte	16 -0 1	+0- n	O D	n = -^	310	MN 21215
			1 1790	, 26	00	トルかい	CIT t	151 17	E BY	IL HA	UICE	My 21215
	State	31. Date filed (Month, Day, Year)	ns Registra	r's Signature	Socie	•						
	Registrar	DEC 1 2 20	UU TO	17	C-9715 C							

			1 - For State Registrar	State of M	laryland		artmen <i>rtificat</i>			ind M	_	gienę Reg. Nd	211116	3955	8
	Physici	an	Decedent's Name (First, Middle, Last	st)							2. Date of De Month	Da	y Year	3. Time of Death	
	/Medio		James Phelan, Sr. 4a. Facility Name (If not institution, give	e street and number	·)		4b. City.	Town, or	Location of	f Death	12/7		. County of Dea	2:05 p.m	L
	Examir	ier	6070 Montgomery F		,			crido		, oouth			Howard		
	Funeral		5. Social Security Number 6. S		ge (In yrs. la	ast birthday)	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th		rthplace (State or Fore ountry)	ign
	Director		216-42-1339	20 F	62	Yrs.	, mortal d	Juys	TIODIS		2/3/19		1	yland	
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City,	, Town or Lo	cation							10d, Inside City Limi	its
	Marylan Ff ehow Iind a	tor	MD Howard C		E	1krido	re							1 □ Yes 2 📆	No
	th the	Director	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What C	ountry?	
	23a vi		6070 Montgomery Ro	ad			210	075				USA			
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or Itame 23e or 28e-f show event, the Medical Examiner must be natified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 X Yes 2 If Yes, Give Year or Dates:	? ] No		Was Decect f Yes, spec l ☐ Yes	offy Cubar	n, Mexican,	in? (Spec , Puerto F	cify Yes or No Rican, etc.)	)-	14. Race - Am Black, Whi		
21215-0036	2 hou		15. Decedent's Ed	lucation		16a. Deced	ient's Usua	I Occupa	ition			16b. K	ind of Business	Vindustry	
218	thin 7 en "n Med	aldi	(Specify only highest gra	de completed) College (1-4or	5+)	(Give life. l	kind of woi DO NOT us	rk done d se retired)	uring most	of workin	g			,	
2	filed within Hygiene. Sther then set, the Ment.	Completed	12	2		Chief	Hosp:	ital					S. Navy		
Ind	be fill d oth	Be	17. Father's Name (First, Middle, Last)						18. Mother	's Name	(First, Middle	, Maiden	Sumame)		
3	should be and Mental s marked o	2	James A. Phelan			401-14-15		(0)	Arett						
			19a. Informant's Name/Relationship (7	, , ,								-	or Town, State,		
ē,	s 1 and 2 if Health itam 27 i		Patricia Phelan/Wi 20a. Method of Disposition	.те	20b. Pla	ace of Dispo	sition (Nan	ne of			SIKTIQ		ID 2107 ocation - City or		
9	m 0 .		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		9	metery, cren bwridoe	•		,	12/1	1/06	E-11	rrideo	Marriand	
Baltimore,	교문활동 .		21. Signature of Funeral Service Licen		Treac	22	. Name an	d Addres	s of Facility	,			150	Maryland	_
ä	Depa Impo any in		Man			Ga	ry L.	Kau	ıfman	Fune	eral Ho	ome (	MMP,	Inc.	
6	₩ ¥9		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause one cause on each	d the death.	Do not ent	er the mode	e of dying	, such as c	ardiac or	respiratory a	rrest,	Je, 1110	Approximate Interval Between	-
3 5.0	Physician		Immediate Cause (Final disease or condition	. M	ETA	STA	TIC	_	ME	LA	NOM	A		Onset and Death	bs
	/Medical Examiner		resulting in death)	Due to (or as											- San
	Laminer	Į.	Sequentially list conditions,	b. Due to (or as	2 000000	anno of).									
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	DDe to (or as	s a conseque	ance oi):									
<u>,</u>	be executed sicien and burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as	s a conseque	ence of):									
8760,	cate be ex physicien a the burial	dicall		d											
9	tificat ng phy as th	au I													
.O. Box	at the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal c	death 3	Ectopic pro Other (spe						23d. Date of de Month	livery Day Year	
<u>a</u>	that the by detac		Part II. Other significant conditions co	ontributing to death !	but not result	ting in the ur	derlying ca	ause give	n in Part I.		23e. Did to	obacco u	ise contribute to	the cause of death?	
ds	90 Pe	d by									10	Yes 2	XNo 3□P	robably 4 Unknow	vn
Vital Records,	> 40 0	Completed									24a. Was	an	24b. Were a	utopsy findings availab	ole
æ	The te h	E O										rmed?	prior to death?	completion of cause of	f
ita		BeC	25. Was case referred to medical						26. Place o	of Death	Check only o	2 No	1 1 10	2 □ No	
of <	S S F	Tof	examiner? 1  Yes 2 No	Hospitat: 1   Inpati	ent 2 E	R/Outpatien	3 DO	A Othe	r. 4 🗆 Nurs	sing Hom	e 5 Resid	dence	6 □Other (Spe	cify)	
Ē		on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time of Injury	-	Bc. Injury Work	?		3d. Describe h	now inj <i>u</i> r	y occurred		
Sio	ten Jeat tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be				М		es 2 N						
-	2 8 2 2	Certification:	4 Homicide determined	28e. Place of in	ijury - At nom tc. <i>(Specify)</i>	ne, farm, stre	et, factory	, office		28	City or Tov	Street an vn, State	d Number or R )	ural Route Number,	
	To the Hospital or At within 24 hours after of the Funerel Directompletely filled in by	edical C	29a. Certifier (Check only one)  1 Certifying Physical Examples one)	ysician: To the best	of examination	ledge, death on and/or inv	occurred a	at the time in my opi	e, date and inion, death	place, ar	nd due to the	cause(s) date and	and manner as	s stated. e to the cause(s)	
	o the	Med	29b. Signature and title of certifier	and manner st			29c	License	number			29d. Dat	e signed (Mont	h, Day, Year)	
	730		> F11) (801	less	MD			DIC	354	4			4 4		
•	0		30. Name and address of person who o	completed cause of	death (Item 2	23a) (Type, I	Print)			1			10120	- 10	
	ľ		E.W. COLÉ S	T AGNE	5 9	00 (	ATON	AVE	BI	ALT	IMOR	8/	40 6	06	
	Sta Registr		31. Date filed (Month, Day, Year)	32 <b>3</b> 4 jisti	rar's Signatu	re .	act D								

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Maryla	and / Dep	artme		ealth and	Mental Hyg	iene () ()	5 39560
Physic /Medi	cal	Decedent's Name (First, Middle, Last)     Edgar M.  4a. Facility Name (If not institution, give st			4h Ci	t. Tour	Location of De		r ¹¹0, 2č	
Exami	ner	Manor Care Ruxto			4B. CI	Town, or	n	atri	4c. County of Baltin	iore
Funeral Director		240 30 3033	M 2□F 7. Age (In y	rs. last birthday Yrs.	Month	der 1 Year ns Days	If Under 24 Hi Hours Min		1926 N	N. Birthplace (State or Foreign North Carolina
death with the Maryland me 23a or 28a-1 ehow rmust be redified at	tor	Usual Residence of Decedent  10a. State  10b. County  Harford		City, Town or L Joppa	ocation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
With the	Funeral Director	10e. Street and Number 400 Avery Court			10f.	Zip Code 2108	35	1	0g. Citizen of Wh	
_ b = 5	þ	11. Marital Status 1:  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1 U.S. 13.		cedent of Hispecify Cubar	spanic Origin? n, Mexican, Pue Specity:	(Specify Yes or No- erto Rican, etc.)		American Indian, White, etc. White
Mary iarna 4 (4 15-0050) d 2 should be filed within 72 hours after th and Mental Hygiene. If is marked other than "netural", or ite traumatic event, the Madical Examina	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	e kind of	sual Occupa work done d T use retired;	uring most of w	vorking	16b. Kind of Busin	·
aryiand Z should be filed nd Mental Hygi marked other umatic event, I	9	17. Father's Name (First, Middle, Last)  John Carl Pope					Nel	<sub>ame (First, Middle, F</sub>    lie May	Summer	
Mar nd 2 sh alth and 27 ia m or traum		19a. Informant's Name/Relationship (Typ Mrs. Anne Eve/ Daug			-			Rural Route Number Darks, Md.		ate, Zip Code)
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic e-		20a. Method of Disposition  1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	omoval from State	o. Place of Disp cemetery, cre rinity	osition (formatory of Epis	Name of or other place Cemet	ery 12-		20c. Location - Ci Long Gr	ty or Town, State een, Md.
Dearnit. Depart Import any inj		21. Signature of Funeral Service License		2	Ruch 105	and Addres K TOWS U York	on Factione	eral Home, owson, Md.	Inc. 21204	
Physician /Medical Examiner and physician and physician and the physician and the physician sit in the physician s	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failur? List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a cons	sequence of):				diservices		Approximate Interval Between Onset and Death
The law requires that the death certificate. The law requires that the death certificate site has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	□Ectopid □ Other	pregnancy (specify)			23d. Date of Month	,
w requires that the second of	þ	Part II. Other significant conditions cont	inbuting to death but not	resulting in the	underlyin	g cause give	n in Part I.			ute to the cause of death?
VICAL MECONAS, lician: The law requires t certificate has been signe rector, page 2 should be o	Completed							24a. Was a autops perform	ned? dea	ore autopsy findings available of to completion of cause of ath?
Physicia Physicia this cert	To Be	25. Was case referred to medical examiner?  1 Yes 25 No	ospital: 1   Inpatient 2	P.□ER/Outpatie	ent 3	DOA Othe		eath <i>Check only on</i> Home 5 Reside		(Specify)
ing ling l		27. Manner of Death  1 ⊠Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time Injury	of M	28c. Injury Work	at ? ∕es 2 □ No	28d. Describe ho	w injury occurred	
To the Hospital or Attend within 24 hours after death To the Funerel Director: v completely filled in by the f	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)				City or Towr	, State)	or Rural Route Number,
Lothe Hospital within 24 hours in the Funerel completely filled	Medicai	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of my er: On the basis of exam and manner stated.	knowledge, dea ination and/or i	th occurr nvestigati	ed at the tim ion, in my op	e, date and pla inion, death oc	ce, and due to the ca curred at the time, di	ause(s) and mann ate and place, and	er as stated. d due to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	1 2001	110		29c. License	number 5 4 4	24 2	9d. Date signed (	Month, Day, Year)
1214		30. Name and address of person who cor	impleted cause of death (	Item 23a) (Type	, Print)	1100	#20	9 Timor	num N	10 21093
St Regist	ate trar	31. Date filed (Month, Day, Year)  DFC 1 2 201	32. Registrar's Si	gnature	parte	)	77 ~	1 11/10/	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	

			For	State of Mai	ryland				nd Mental Hy		_	00001
			1 - State Registrar				tificate of			Reg. No	2006	39561
	Physici	an	1. Decedent's Name (First, Middle, Last)	***					2. Date of D Month	/ Da		3. Time of Death
	/Medic	al	Kenneth	E.	k	Roy	[41 0) T	.1	Decem		8, Dea	
	Examin	er	4a/Facility Name (If not institution, give	o 16 )	Mol	12 No.	4b. City, Town, o	en Buri		40	. County of Death Anne Arı	
	Funeral		5. Social Security Number 6. Sex		in yrs. la	st birthday)	If Under 1 Year	If Under 24		irth		nplace (State or Foreign untry)
	Director		220-24-0963	M 20 # -	78	Yrs.	Months Days	Hours	Min. 8. Date of B	22, Year	928 West	t Virginia
	A. Pud		Usual Residence of Decedent  10a. State 10b. County		10c. City,	. Town or Lo	cation					10d. Inside City Limits
	within 72 hours after death with the Maryland ans. Then "naturel", or iteme 23s or 28s-f show the Jical Examiner must be notitied at	ō	Maryland Anne Ar		,	thicum						1 ☐ Yes 2 ☑ 1√0
	r 28e	Funeral Director	10e. Street and Number	under	штис	LITTCUIII	10f. Zip Code			10g. Ci	tizen of What Co	untry?
	th with	a D	431 Applegate Cour	t			210	90			U.S.A.	
	r dea	ne.		12. Was Decedent Ev Armed Forces?		5. 13. V	Vas Decedent of H	lispanic Originan, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Amer Black, White	
36	rs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1. Yes 2 No If Yes, Give Year or Dates:	)	1	□ Yes 2 🖳 No	Specify:			Specify: 1.11	hito
21215-0036	2 hou	ted I	15. Decedent's Edu	cation		16a. Deced	lent's Usual Occup	pation		16b. K	(ind of Business/I	hite Industry
215	thin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	)	(Give life. L	kind of work done OO NOT use retired	during most o d)	of working			
N	filed with Hygiene. other the		11	N/A		Aut	o Mechan				Service	Center
and	ould be fi Mental H arked otl	Be	17. Father's Name (First, Middle, Last)  Roy  De	lbert	T	Roy		Glad	s Name (First, Middle	e, Maider	Sumame)	Stemple
Maryland	2 should and Men is marke eumatic	우	19a. Informant's Name/Relationship (Ty.		1		a Address (Street		or Rural Route Numi	her City	or Town State 7	
	ges 1 and 2 should be filed within 72 hours after death with the Marylen at of Heelin and Mental Hygiens. If item 27 is marked other then "naturel; or iteme 23a or 28e-f show if it item 27 is marked other then "naturel; or iteme and it is notified at or other treumatic event, the Modical Examinating must be notified at		Anna R. Roy (Wife)						t Linthicu			
ore,	es 1 a of Hee f item r othe	- 3	20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of natory or other place	ce)	Date	20c. L	ocation - City or	Town, State
Ē	Pages ment of ent: If it ury or o		1 ☐ Surial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emovai from State	G1e	en Hav	en Mem.	$Pk. \mid 1$	2/12/06	G1e	en Burnie	e, Maryland
Baltimore,	permit. Pages Department of Importent; If i eny Injury or once.		21. Signature of Funeral Service License	11/10		M 2	Name and Addre CCully-Po 37 East	olynial Pataps	k Funeral	Home	P.A.	ryland 21225
			23a. Papt. Enter the disease, or complishock, or heart failure. List only or	cations that caused the	he death.						,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			icoti	ous o	2 250	Ohocoal	Ccar	cor	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a				9	0 1			3
		Je.	Sequentially list conditions,	Due to (or as a	Lonsmous	ance on						
16	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		00/10040	31.00 0.7.						
0,	ite be executed ysicien and he burial-transit	Еха	resulting in death) Last	Due to (or as a	conseque	ence of):						
8760,	ate be physici the bu	dical		J								
x 68	ding p	Physician/Med	IF FEMALE:	3c. If yes, outcome of	foregnan	ncv				- (7)	22.1.5	
Вох	atten 1 for u	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth 2 4 Pregnant at ti	Fetal	death 3□	Ectopic pregnancy Other (specify)	4			23d. Date of deli Month	very Day Year
P.O.	t the c by the	hys	9 Unknown	9□ Unknown			02					
ds, F	The law requires that the death certificate be exite has been signed by the attending physicien page 2 should be datached for use as the buria	ρ	Part II. Other significant conditions con			Iting in the ur		ren in Part I.			use contribute to	the cause of death?
Records,	w requir been si should	Completed	E mah	cem a					24a. Wa	s an	24h Were au	topsy findings available
Re	The lav	E O	Recent	Stra	L 0				aute per	opsy formed?	pnor to death?	completion of cause of
Vital		Be C	25. Was case referred to medical	3,10			-	26. Place o	1 Tyes  If Death   Check only		TUTES	2 YNo
>	Physic this ce al direc	70 6	1 103 230 110	lospital: 1 Inpatient	2 🗆 E	R/Outpatien	t 3 DOA	19f: 4□ Nurs	ing Home 5 Res	idence	6 ☐Other (Spec	cify)
Division of	ding Physician h. After this certifi funeral director	0	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	28c. Injur Wor	rk?	28d. Describe	how inju	ry occurred	
isic	i or Attendi efter death. Director: A I in by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injur	y - At hon	ne, farm, str		Yes 2 No		(Street a	nd Number or Ru	ral Route Number,
Ö	ital or / rs efter al Dire	Certification:	4 Homicide	building, etc.	(Specify)	)			City or To	wn, State	э)	
	To the Hospital or Attending Physician within 24 hours eiter death. To the Funeral Director Attachs is certification of the funeral director completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Examination	sician: To the best of ner: On the basis of e and manner state	examination	vledge, death on and/or inv	occurred at the til restigation, in my o	me, date and ppinion, death	place, and due to the occurred at the time	cause(s , date an	) and manner as d place, and due	stated. to the cause(s)
	To the within To the Comp	ž	29b. Signature and title of certifier	/ 0			29c. Licens	e number		29d. Da	ite signed (Month	n, Day, Year)
			1 / was st	We TH	MD		D	242	87	100	cem 60	r 8, 2006
	10+1		30. Name and address of person who co		ath (Item :	23a) (Type,	4	arles	E Wiles		112	14 10
	Sta	te.	31. Date filed (Month, Day, Year)	282. Registrar	's Signatu	ure •	edica	1 Cev	iter 0	-len	BUSA	16 MM 17
	Registr		DEC 1 2 2006	Maria	B.	Gosse	20					

			1 - For Amend #31 PER	DVR G86 Marylan	d/Gept Cer	Intment of Facilities the transfer of the tran	lealth and M <i>Death</i>	lental Hygier	2006	39562
	Dharaisi		1. Decedent's Name (First, Middle, Las					2. Date of Death	ay Year	3. Time of Death
Apr.	Physicia /Medic		MARUIN KA	ymond				/	07 2006	4:08 M
	Examin	er	4a. Facility Name (If not institution, give	1		1.	r Location of Death	4	c. County of Death	
-			5. Social Security Number 6. Se	ex 7. Age (In yrs. I	act hirthday)	If Under 1 Year	ORE   If Under 24 Hrs.	8. Date of Birth	N/A	wless (Otata - "Free!
О	Funeral Director			M 2□F 66	Yrs.	Months Days	Hours Min.	(Month, Day, Yea	Gou	place (State or Foreign ntry)
20	*		Usual Residence of Decedent	- 00				September L	+, 1740 PJAK	giima
	ryland how		10a. State 10b. County		, Town or Lo					10d. Inside City Limits
	e Ma Ba-f s	Director	MARYLAND NA	13A1	timo	RE				1 🔼 Yes 2 🗆 No
	vith the	Dire	10e. Street and Number			10f. Zip Code	_	10g. (	Citizen of What Cou	ntry?
	s 23g	eral	608 W. Latayette	12. Was Decedent Ever in U.S	C 10 1	Was Danadari of H	Janania Origina (Con	oif. Van an Na	USA 14. Race - Ameri	con Indian
	ter de iner i	Funeral	11. Marital Status  1 Never Married 2 Married	Armed Forces?  1 ☐ Yes 2 ☒ No	s. 13. V	f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, White,	
920	urs a	by	3 ☐ Widowed 4 ♥ Divorced	If Yes, Give Year or Dates:	1	I□Yes 2⊠No	Specify:		Specify:	IN AMERICAN
5-0036	be filed within 72 hours after death with the Maryland rital Hygiene. so other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Deced	lent's Usual Occup	ation during most of worki	16b.	Kind of Business/Ir	
21	within ene. than "	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	NOT use retired	1 (- , ,	· /-		T. 1
121	filed w Hygier ther th	ខិ	17 Fether's Name (First Middle Lept)		Wate	e Front F	-aver Work		PAM Ship -	-/Rode
anc	ntal hed or	Be	17. Father's Name (First, Middle, Last)	/			Un //	(First, Middle, Maid	[/ j	
Maryland	should b nd Menta marked matic e	은	19a. Informant's Name/Relationship (7	Voe. Print)	19b. Mailin	o Address (Street	And Number or Bura	DRIE LOT al Route Number, Ott	1000 Lor Town State 7i	n Code)
<u>≅</u>	and 2 sho lealth and m 27 Is mi her traumi		1/2/	ind	11	w. Lafay	11	BAHIMORE	4/ /	1 01217
ē,	- T m =		20a. Method of Disposition	20b. PI	lace of Dispos	sition (Name of	; [		Location - City or T	
Ë	Pages nent of I int: If Ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		ARMEL	Decemb	ERIC DI	MAKE MAR	ulated .
Baltimore	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Lice	see			ss of Facility	FernerA	e servi	ce
<u>m</u>	e a E e e		ralled m.	Cenelace	1 34	Ancy M.	oklin St K	3/1/fimire 11	Martinal	21229
è			23a. Part 1. Emer the disease, or comp shock, or heart/failure. List only of	lications that caused the death one cause on each line.	. Do not ente	er the mode of dyir	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between
Ñ	Physician		Immediate Cause (Final disease or condition resulting in death)	a. METASTITIC	COR	SHOMA	OF M	ID- ESOP	4A6 45	Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a consequ					7	
	- (Aka)	F.	Sequentially list conditions,	b. Due to (or as a nonsequ	ience of):					-
	uted ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Õ	an an		resulting in death) Last	Due to (or as a consequ	ience of):					
8760,	ficate be executed physician and the burial-transit	dical		d						
Θ	ertifica ing ph e as t	Med	IF FEMALE:						2.	
Вох	death certific e attending p d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnal 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy	1	9	23d. Date of deliv Month	ery Day Year
<u>o</u> .		sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5∟	Other (specify)			111011111	buy rous
<u>α</u>	that the de ned by the a detached t		Part II. Other significant conditions of	ontributing to death but not resu	Iting in the ur	iderlying cause give	en in Part I.	23e. Did tobacco	use contribute to t	he cause of death?
ds	w requires that been signed to should be det	d b	DIABETES	MELLITUS	•			1 ☐ Yes	2☐No 3☐Proi	bably 4 🛎 Unknown
<u>S</u>	The law requires that the te has been signed by the page 2 should be detached.	Completed by	ILLAGE DITT LOCK	E ISEMIT	Ø 10	TNI.		24a. Was an	24b. Were auto	opsy findings available
Re	The lavate has	mo	POJICK JE HOLV	F 100 101	<i>y-/-</i> 3	IC HSU		autopsy performed?	prior to co death?	empletion of cause of
ţa		Be C	25. Was case referred to medical examiner?				26. Place of Death	1 Yes 2. 1 (Check only one)	VO TETES	2   10
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sio	Attending r death. ector: After	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	OO- Diese of leiters. As he			Yes 2 □ No	201		
Division or Vital Records,	al or Attend after death   Director: / d in by the f	Certification:	4 ☐ Homicide determined	28e. Place of injury - At hor building, etc. (Specify	me, rarm, stre	эет, тастогу, опісе	2	28f. Location (Street : City or Town, Sta	and Number or Run ite)	al Route Number,
	spital lours neral		29a. Certifier 1 🗷 Certifying Phy	/sician: To the best of my know	viedge, death	occurred at the tir	me, date and place, a	and due to the cause	(s) and manner as s	stated.
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Examone)	iner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my o	pinion, death occurr	ed at the time, date a	nd place, and due t	o the cause(s)
	To the within To the complex c	Me	29b. Signature and title of certifier	54 A C		29c. Licens	e number	29d. D	ate signed (Month,	Day, Year)
			Jogas 9	I few, he	-		D14900	)	12-12-	06.
-	17		30. Name and address of person who o		23a) (Type, I	Print)	(0)		7 _	Day, Year)  - 06  - 17
			DR. ANGELITA 31. Date filed (Month, Day, Year)	TOPAGO / 7	/ ナ/	JO 1841	J L VAME 1;	4 pro 1	BALTIMOR	E, hD 2/217
	Sta Registr			DEC 1 2 2006	E.	ja 1	0.00			
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			1 - For State Registrar		State of	Marylan		artment of F		nd Ment		ierre	06	395	63
	- 3		1. Decedent's Name (Fir	rst, Middle, Last)							ate of Deat	h		3. Time o	f Death
	Physici		Harry	Rimme	_						lonth C 9	2006	Year	2:05	A M
	/Medic	_	4a. Facility Name (If not			oer)		4b. City, Town, o	r Location of [		c. ,		ty of Death		A
	Funeral	iei	Washington 5. Social Security Number	er 6. Sex	7.	pital Age (In yrs.	last birthday)	Takoma If Under 1 Year	If Under 24	Hrs. 8. D	ate of Birth		ntgon 9. Birth	place (State	or Foreign
	Director		215-14-724	1 100	M 2 F	85	Yrs.	Months Days	Hours		18,			intry) (land	
	P.		Usual Residence of Dec			1									
	anylan ehow	_		o. County	_		y, Town or Lo							10d. Inside C	
	Ba-f	cto	Maryland P	Prince Ge	eorge's		Univer	sity Parl	k					M_ Yes	2 🗌 No
	or 2	Director	10e. Street and Number					10f. Zip Code			1	0g. Citizen of	f What Cou	intry?	
	23e	ral	4219 Van B						782			USA			
	teme	Funeral	11. Marital Status	1	<ol><li>Was Deceded Armed Force</li></ol>	es?	.S. 13.	Was Decedent of H f Yes, specify Cub	lispanic Origir an, Mexican, f	n? (Specify Y Puerto Rican	es or No-		ace - Ameri ack, White	ican Indian, , etc.	
36	be filed within 72 hours after death with the Maryland nat Hygiene. sd other then "neture!", or iteme 23e or 28e-1 ehow event, the Medical Examinar must be modified at	by Fu	1 Never Married 3 Widowed 4		1 Tx Yes 2 If Yes, Give Year or Date	□Nº WWII		1 ☐ Yes 2√€ No					ity: Whi		
21215-0036	hou	ed		Decedent's Educ			16a Dece	dent's Usual Occur	nation			16b. Kind of	Business/le	ndustry	
5	in 72 n" c	Completed	(Specify or	nly highest grade	completed)		(Give	kind of work done DO NOT use retire	durina most a	of working		100. 70110 01	Du3111033411	noustry	
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	Hyg Hyg other	Ö	17. Father's Name (First	t, Middle, Last)			Conci	aces num.			t, Middle, I	Maiden Suma		OI Ma	цутан
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other then "traumatic event, the Men	To B	James H. R	Rimmer					Mars	z Alic	o Tat	tersal	1		
<u></u>	ges 1 and 2 should t of Health and Men if Item 27 is marke or other traumatic	F	19a. informant's Name/		e, Print)		19b. Mailir	ng Address (Street						ip Code)	
N	id 2 in art lith ar 27 is 27 is		Anna A. Ri	mmor - V	H.f.o							-			
ē,	Health Health tem 27		20a. Method of Dispositi		ATIC	20b. F	Place of Dispo	Van Burer		Date		Park, 20c. Location			
Baltimore,	permit. Pages 1 and. Department of Health Important: If Item 27 any injury or othar tr once.		1 ⊠Burial 2 □ Cre		moval from St	ate l		natory or other pla n Cemete:		2/13/2	006	Bronts	boot	Mary1	an d
Ē	rt. P.		4 ☐ Donation 5 ☐ 21. Signature of Funeral	/	<del></del>	1010									allu
Ba	permit. Departrimports any injustre		21. Signature of Purieta	3617104 2100130	Tlan	_		2. Name and Addre 39 Balti							
	WATER DE		23a Parti Enter life in	seare or complic	anions that cau	ised the deat							МД	20781 Approxima	to
			shoot or heart failure. List only on- cause on each line.												tween Death
M	Physician		disease or condition resulting in death)		Kespi	rator	y Ja	lure .	secon	da	Z				
	/Medical Examiner		rossiang in doutin	(	Duglo (or	as a conved	(uender of):	20.	Les	Luca	01	, ,			
30		<u>.</u>	Sequentially list condition	ons, b.	end	nu	pe 0	wrone	0000	) rue	700				
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	and I-tran	Examiner	that initiated events resulting in death) Last	' с.	Due to los	as a conseq	wanto of):	con con							
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87		dical		d.									-		
9 ×	leath certific attending p	/Me	IF FEMALE:	25	c. If yes, outco										
Вох	atten for us	ian	23b. Was decedent pre- in the past 12 mon	gnant	1 ☐ Live birt	h 2 ☐ Feta	ıl death 3[	Ectopic pregnanc	У				ate of deliv Aonth	very Day	Year
o.	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Pregnar 9☐ Unknow	nt at time of d m	leath 5L	Other (specify) _						,	
<u>a</u>	hat the deby	P.	Part II. Other significan	t conditions con	tributing to dea	th but not res	ulting in the u	nderhina cause an	en in Part I		Pa Did to	acco usa co	ntribute to	the cause of	doath?
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/ita	Physician: this certificant	Be	25. Was case referred to examiner?						26. Place of	f Death   Che	ock only on	θ)			
) L	hysi his c	2	1 ☐ Yes 2 🗹 No	He	ospital: 1 🔄 np		ER/Outpatier		4 🗆 Nurs	ing Home	5 🗌 Reside	ence 6 🗆 O	ther (Spec	ify)	
ū	fter t	ü	27. Manner of Death 1 ⊠Natural 5	☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury	28c. Injui Wor	y at rk?	28d. [	Describe ho	w injury occu	urred		
Sio	death.	cati	2 Accident	investigation Could not be				M 1 🗆	Yes 2 □ No	0					
Division of Vital	if or Attend after death   Diractor: ,   d in by the f	Certification:	3 ☐ Suicide 6:	determined	28e. Place o building	f Injury - At hi g, etc. <i>(Specif</i>	ome, farm, sti fy)	eet, factory, office			ocation (St lity or Town		nber or Rui	ral Route Nur	nber,
	ital c														
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medicai	(Check only 2	Certifying Phys Medical Examin	er: On the bas	is of examina	owledge, deat ition and/or in	h occurred at the til vestigation, in my o	me, date and popinion, death	place, and d occurred at	ue to the ca the time, da	ause(s) and nate	nanner as e, and due	stated. to the cause(	s)
	thin the mple	Mec	one) 29b. Signature and title(		and manne	n Stated.	······································	29c. Licens							
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	171		30. Name an lade ess of	of person who cor	npleted cause	/		Print)	1500 F						
100	J		JOUR	nna by	- /-	uniu		<i>A I</i>	Silver	Sprin	ıg, MI	209	10		
3	Sta Regist		31. Date filed (Month, D	ey, Year) EC 1 2 20		jutrar's Signa	ature	9-10-							
1	negist	rai	טנ	10 I & 20	UO L	William .	15 1	1542							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year James Edward Rossie Dec 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 6463 Bowersox Rd. New Windsor Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days Hours 1 XM 2 ☐ F 73 226-38-2129 May 4, 1933 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County 1 ☐Yes 2 No Maryland Carroll New Windsor 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6463 Bowersox Rd. 21776 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 XYes 2 No 1953− If Yes, Give Year or Dates: 1955 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify. Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Washington Gas Company 9th Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Floyd Rossie |Lizzie Sturgill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2463 Bowersox Rd. New Windsor, MD 21776 Jackie Rossie (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/15/2006 Parklawn Mem Park Rockville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Furrier-Queen Funeral Home and Crematory, I 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Small NOW disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury

law requires that the death certificate be executed and use as the burial-trag Division or Vital Records, P.O. Box 68760, sbeen signed by the attending physician should be detached for use as the buria has S

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or Items 23a or 28a-f show edical Examiner must be notified at

Medical

traumatic event, the

and Mental Hygiene.

permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun once.

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Baltimore, Maryland 21215-0036

page certificate director this funeral After death.

Physician/Medical Completed by Be Certification: To

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Examiner

or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the I

Medical DH

State Registrar

DHMH 17 Rev 1/2001

らしてか

6 Could not be determined

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

51705 12-12-06

DR, Kertminnter MD21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BURNEYS WIN Merl

31. Date filed (Month, Day, Year)



Place of injury - At home, farm, street, factory, office building, etc. (Specify)

**ORIGINAL** 

			For	e of Marylan					ental Hy	giene		
			- State Registrar		Cer	tificate	of Death			Reg. No.	2006	39565
	Physicia	an	1. Decedent's Name (First, Middle, Last)  June  T						2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic		1.	- d	ко	eth	wn, or Location	of Dooth	Dec.	6	2006 County of Death	12:00P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street as 7 Gilmore Street	ia number)			Burnie	oi Death			nne Arun	ide1
	Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y	ear If Under	r 24 Hrs.	8. Date of Birt	h	9. Birth	place (State or Foreign
	Director		219-28-4150 1□M 28	7:	3 Yrs.	Months D	ays Hours	Min.	April (	9,193	33	mtry) MD
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	tv. Town or Lo	cation						10d. Inside City Limits
	Manyla f sho	ò	MD Anne Arundel	G1e	n Burni	Le						1 □ Yes 2 No
	r 28a- notif	irec	10e. Street and Number			10f. Zip Co	ode			10g. Citiz	zen of What Cou	ntry?
	death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral Director	7 Gilmore Street			2106	1			U	S.A.	
	r deal	ner	11. Marital Status 12. Was	Decedent Ever in U ed Forces?	I.S. 13.	Was Deceden If Yes, specify	t of Hispanic Or Cuban, Mexica	ngin? (Spe an, Puerto l	cify Yes or No Rican, etc.)	- 1	<ol> <li>Race - Ameri Black, White</li> </ol>	
S	s afte	by Fu	1f Ye	Yes 2 XNo es, Give r or Dates:		1⊡Yes 2🏋	No Specify	<i>'</i> :			Specify: Wh	ite
1215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. d other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the M dical Examiner must be notified at		15. Decedent's Education	or Dates.	16a. Deced	dent's Usual C	Occupation			16b. Kir	nd of Business/Ir	ndustry
<u>ე</u>	hin 72 9. an "ng M die	Completed	(Specify only highest grade complete Elementary/Secondary (0-12)  Coll	eted) ege (1-4or 5+)	(Give life, l	kind of work o DO NOT use r	done during mo etired)	st of worki	ng			
N	ed wit	Com	12		Recep	ptionis					stingho	use
and	ild be fill fental H rked oth	Be	17. Father's Name (First, Middle, Last)						(First, Middle,		,	
	s 1 and 2 should be if Health and Mental item 27 is marked other traumatic ev	은	Edward Harold Thomas  19a. Informant's Name/Relationship (Type. Prin	t)	19h Mailir	nn Address (S			Louise		r Town, State, Zi	in Code)
Mary	nd 2 s Ith an 27 is i		Mr. Jack Roeth /Husba	•	1	-	Street			-		p Gode)
ō,	s 1 and if Health item 27 other tr		20a. Method of Disposition	20b.	Place of Dispo	sition (Name	of	Dec.			cation - City or T	own, State
Ê	Page nent o int: If iry or		1 X Burial 2 □ Cremation 3 □ Remova 4 □ Donation 5 □ Other (Specify)	from State	en Have	,	· / . i	20		G1e	n Burni	e, MD
Baitimore,	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Signature of Funeral Service Licensee	v mor			Address of Facil	21	ngletor	ı Fun	neral Ho e, MD 21	me, P.A.
			23a. Part1. Enter the disease, or complications	that caused the dea							:, MD 21	Approximate
	Physician		shock, or heart failure. List only one caus Immediate Cause (Final disease or condition	1.1	orio						1	Interval Between Onset and Death
	/Medical		regulting in death)	ue to (or as a con e	quence of):					,		2mix
	Examiner	L	Sequentially list conditions, b.	Chor	vico	botr	sch)	1e/	PINO	919	ease	10 905
	bed sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a conse	quence of).							,
,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Examine	that initiated events c c	ue to (or as a conse	quence of):							
8760	ysicial	dical	d									
9	ng ph as th	Medi	IF FEMALE:		0.00							
X R R	leath certific attending p	ian/l	23b. Was decedent pregnant 123c. If y	es, outcome pf pregr Live birth 2 Fet	al death 3	Ectopic preg				2	23d. Date of deli-	very Day Year
	at the de by the a tached f	Physician/Me	1 Vas 2 WNo 4	Pregnant at time of Unknown	death 5L	Other (spec	ify)					
<u>.</u>	res that t signed by be detac		Part II. Other significant conditions contributing	g to death but not re	sulting in the u	inderlying caus	se given in Part	ı L	23e. Did t	obacco u	se contribute to	the cause of death?
Records,	w requires been sign should be	d by	Rheumato	2 Arth	art	<b>&gt;</b> .			1	Yes 2[	□ No 3 □ Pro	obably 4 ☐Unknown
ပ္လ	aw reis bee	Completed	Commony	Ather	050	eros	15		24a. Was		24b. Were aut	opsy findings available
		mo;	Dearessi	ie Dis	cock	$\sim$			auto perfo 1⊟ Yes	psy ormed? 2 No	death?	ompletion of cause of 2□ No
Vita	sician: The law scertificate has b irector, page 2 s	Be C	25. Was case referred to medical examiner?	70015	01-00		Τ.	ce of Death	(Check only			
	Physic rthis c	မ	1 ☐ Yes 2 No Hospita	1 Inpatient 2	ER/Outpatier						6 □Other (Spec	ify)
ivision or	ding Afte fune	ion:	1 Natural 5 ☐ Pending	Date of Injury (Month, Day Year)	28b. Time o Injury	M 280	lnjury at Work? 1 ☐ Yes 2 ☐		28d. Describe	now injur	y occurred	
ISI/	Atten deal sctor	fical	2 Accident	Place of injury - At I building, etc. (Spec	jome, farm, sti							ral Route Number,
á	s after al Dire	Certification:	4 ☐ Homicide determined	building, etc. (Spec	etty)				City or To	wn, State	)	
	To the Hospital or Attent within 24 hours after death To the Funeral Director completely filled in by the	edical (	29a. Certifier (Check only one)  1 Certifying Physician: 2 Medical Examiner: O ar	To the best of my kn the basis of examin d manner stated.	nowledge, deat nation and/or ir	th occurred at nvestigation, in	the time, date and my opinion, de	and place, eath occur	and due to the red at the time	cause(s) date and	) and manner as d place, and due	stated. to the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier	$\cap$		29c. L	icense number		_	29d. Dat	te signed (Month	ı, Day, Year)
			> Cullent	denut	-		0208	35			12/07	12006
•	1		30. Name and address of person who complete	d cause of death (Ite	, ,		(	2 4	0 ~			/2006 nd 21228
			31. Date filed (Month, Day, Year)	32. Registrar's Sign	den de	<u> </u>	tc 200	1500-	mo	C, 1	naryk	nd 21228
	Sta Regist	ate rar	DEC 1 2 200	377	A STATE OF THE PARTY OF THE PAR	A	2				)	
			SEO 7 10 100	South the Bank	1.14	RATE AND L						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39566 Certificate of Death 2. Dete of Death 1. Decedent's Nama (First, Middla, Last) DECEMBER 6 2006 **Physician** REAVES 10 AM NATALIE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number, Examiner 7. Aga (In yrs. last birthday) | If Under 1 Yaar | If Under 24 Hrs. | 8. Data of Birth | Months | Davs | Hours | Min. | (Month, Dey, Year) Futurecare - Charles Village 3 5. Social Security Number Birthplaca (Stata or Foraign Country) **Funeral** Days 1□ M 2X F 04/17/1958 48 217-70-1084 Director Usual Rasidance of Decedent 10d. Insida City Limits 10a. Stata 10b. County 10c. City, Town or Location 7 is marked other than "natural", or ftems 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 1 Yas 2 □ No Funeral Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 2327 N. Charles Street 21218 USA 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 🔀 No Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Nevar Married 2 Married African American 1 ☐ Yas 2 X No Spacify: Baltimore, Maryland 21215-0020 If Yas, Giva Yaar or Datas: þ 3 ☐ Widowed 4 Divorced Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) cours, Elementary/Secondary (0-12) Collega (1-4or 5+) 12th cook Harbor Cruise 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) 2 should be a Jerome Spencer Mittia Hayes 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. fnformant's Name/Ralationship (Type, Print) Item 27 Is Theresa Reaves / Daughter Health 2520 Edmondson Avenue; Baltimore, Maryland 21223 20b. Place of Disposition (Name of cematery, cramatory or other place) 20c. Location - City or Town, State Date 20a. Mathod of Disposition 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from State any Injury or Mount Zion Cemetery 12/11/06 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Addrass of Facility 21. Signatura of Funeral Sarvice Licensee Wylie Funeral Home, P.A. yones 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** END STAGE mutiple sclerosis Immediata Cause (Final disaasa or condition rasulting in death) /Medical Examiner Physician/Medical Examiner physicien end is the burial-transit Sequentially list conditions, if any, leading to immadiata ceuse. Enter Undarlying Cause (Disaasa or injury that initiated avants resulting in death) Last Dua to (or as e consequence of): Box 68760 Due to (or as a consequance of): 98 for use signed by the ar Part II. Other significant conditions contributing to death but not resulting in tha undarlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Completed by should be 24b. Were autopsy findings available prior to complation of causa of daath? 24a. Was an autopsy performed? After this certificate has if funerel director, pege 2: 1 ☐ Yes 2 ☐ No 1 ☐ Yas ☐ No Be 25. Was cesa rafarred to medical axaminar? 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient Othar: 454 Nursing Home 5 - Residence 6 - Other (Spacify) 1 ☐ Yes 2 No 3 DOA edical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Data of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending daath. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: A 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) To the Hospital or Atterwithin 24 hours after date To the Funeral Director completely filled in by the 3 ☐ Suicide Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner es steled.

| Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner estated. 29a. Certifier 29c. License number 29d. Date signad (Month, Dey, Year) 29b. Signature and titla of certifiar D35102 DECEMBER 6 2006 uauy om mo 30. Nama end address of person who complated cause of death (Item 23a) (Type, Print) North Charles Street Baltmore Manylang 5901 HILAYY DON M.D. 32. Flogistrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar DHMH 16 Rev 6/95

**ORIGINAL** 

			For State	State of Mar	-	epartment Certificate			,	0	000	00567
	92		Registrar  1. Decedent's Name (First, Middle, Last	1		Jeruncale	or Deali	(1	2. Date of De	Reg. No.	UUb	3. Time of Death
	Physicia /Medic		Mary E.	2 adzyK	ewyc	-2_			Month	23	Zev (	1/35 AM
	Examin		4a. Facility Name (If hot institution, give	, ,	/		own, or Location	n of Death	mo	4c. (	County of Deat	110
	Funeral Director		5. Social Security Number 6. Se 15-28-0272	x 7. Age ☐ M 2∏ F	(In yrs. last birth	Months	Year If Undo	er 24 Hrs. Min.	8. Date of Bir (Month, Da Aug 17	th ly, Year)	Co	hplace (State or Foreign untry) Vland
	1		Usual Residence of Decedent		13				Aug 17	, 193	ı mary	yrand
	show		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	e Ma	cto	MD Carroll		Taneyt	own						1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip C	ode			10g. Citiz	en of What Co	untry?
	ath w		100 Atrium Blvd					1787			USA	
	er de	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	_	<ol><li>Was Deceder</li><li>If Yes, specified</li></ol>	nt of Hispanic ( y Cuban, Mexic	Origin? (Sp an, Puerto	ecify Yes or No Rican, etc.)	)- 1	<ol> <li>Race · Ame Black, Whit</li> </ol>	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28a-f show the Modical Examiner coust be notified at	ρ	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2	X No Specia	ty:			Specify: wh	ite
5-0	72 h	Completed	15. Decedent's Edu (Specify only highest grad		(	ecedent's Usual Give kind of work	done during m	ost of work	king	16b. Kin	d of Business/	Industry unk
21	within ene. then	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		ife. DO NOT use	retired)					
			12 17. Father's Name (First, Middle, Last)	0		offi	ce mana	_	e (First, Middle	Maidan	Sumana)	
Maryland	o d a b	Be	Arthur Smith									
Ž	d 2 should the and Ment 7 is marked treumatic	2	19a. Informant's Name/Relationship (T)	ma Print1	19h	Mailing Address (			se Jerr			Zin Coda
Ma	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		Diana Mood/daughte	*		O. Box 4				_		
စ်	Heg Heg	1 %	20a. Method of Disposition		20b. Place of D	Disposition (Name	of	KIVE	r Rd Sy		ation - City or	
Baltimore,	0 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☑ Donation 5 ☐ Other (Specify)			crematory or oth						
Ba	permit. Pag Department Important: I any injury o		21. Signature of Funcial Aprice Licens	lade, Direc	1	State Ar Baltimor	-			Balt	imore	Street
	3	11	23a. Palt1. Enter the disease, or comp	lications that caused the	ne death. Do no					ırrest,		Approximate Interval Between
	Physician		shock, or heart failure. List only o	. Pori o	hosal	Maso	MINS	ch.	1904	.0		Onset and Death
30	/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of		ALIBOS					
₹6°	Examiner		Commented the link and divine	h								
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of	):						
	ecute and trans	Examine	Cause (Disease or injury	c								
60,	death certificate be executed ettending physicien and for use es the burial-transit	Ē	1.555	Due to (or as a	consequence or	):						
9289	physic the t	dicai	•	d								
9 X	ding se es	/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy					2	3d. Date of del	
Box	death certific ettending pl	ciar	in the past 12 months?	1 Live birth 2 4 Pregnant at ti	Fetal death	3 ☐Ectopic preg				-	Month	Day - Year
0	by the	Physician/Med	1  Yes 2 No 9  Unknown	9□ Unknown								
0.	requires that the	by P	Part II. Other significant conditions co	ntributing to death but	not resulting in	he underlying cau	ise given in Pai	rt I.	23e. Did	tobacco us	se contribute to	the cause of death?
ğ	w require been sig should b	ed	CHF, CAC	) / [4-	-CV				1 🗆	Yes 2	No 3□Pr	obably 4 Unknown
Vital Records	S S S	Completed							24a. Was		24b. Were au	stopsy findings available
Œ	The este	mo.							perfe	ormed?	death?	completion of cause of
ita	or, efficient	Be C	25. Was case referred to medical examiner?				26. Pla	ice of Dea	th (Check only			
of V	w =	2	1 ☐ Yes 2 No	Hospital: 1   Inpatient	2 ER/Outp	patient 3 DOA	Other: 4	Nursing H	ome 5 Res	idence 6	☐Other (Spe	cify)
0	ng Ph fter thi		27. Manner of Death  1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Ti	me of 28	c. Injury at Work?		28d. Describe	how injury	occurred	
Sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation			М	1 ☐ Yes 2	□No				
Division	i Diffe	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, tarr (Specily)	n, street, factory,	office			(Street and wn, State)	Number or Ru	ural Route Number,
	Hospitel 24 hours a Funeral i	edicai (	29a Certifier 1 Certifying Phy (Check only one)	sician: To the best of iner: On the basis of e	examination and	Saath occurred at for investigation, i	the time, date n my opinion, d	and place leath occur	and due to the rred at the time,	date and	and manner as place, and due	ttated. to the cause(s)
	To the Host within 24 ho To the Functional Completely forms	Med	29b. Signature and title of certifier	and manner state	30.	29c.	License numbe	or	-	29d. Date	signed (Mont	h Day Year)
	F 3 F ŏ		· Franskit	a my		77	517	05		(2-	4-0	m) 21157
750			30. Name and address of person who of M+ PANSURUA	ompleted cause of dea		ype, Print)	DR	He	iarte	mt	or n	M) 2/1157
É	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature							
	Registi	rar	DEC 1 2 200	32. Registrar	s signature	DONEL						
DH	IMH 17 Rev 1/2	001		- Arrange								

ORIGINAL

06-09386		
Robert Ryles	.lr	

dobert Ryles, Jr.		State of Maryland / Department of Health  -For State Certificate of Death	and Mental Hygiene	Reg. No. 200	6 39568
Physiciar	1/	Registrar  1. Decedent's Name (First, Middle,Last)	ES JR 2. Date of I	110 91 110	3. Time of Death 1556 hrs
Medical Examin		1100	wn, or Location of Death	de. County of De.	
		Johns Hopkins Hospital Baltimo			
Funeral Director		5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months		9. 1956	Birthplace (State or eign Country) M. D
aus	-	Usual Residence of Decedent  10a. State			10d Inside City Limits
* .	٥	MD BAltimorE			1 Yes 2 No
uth the Maryland 23a or 28a-f she notified at once	Director	10e. Street and Number $3107$ $BE/Air$ $Rd$ 10f. Zip $2$	/ 2/3	10g. Citizen of What Co	ountry? A
ath with tems 23s	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent 14. Never Married 15. Was Decedent Ever in U.S. 16. Yes, specify	of Hispanic Origin? ( Specify Yes or Cuban, Mexican, Puerto Rican, etc.)	White, etc	
ifter des		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No	No specify:	Specify:	BIACIT
hours a	ed by	during most of worki	ccupation (Give kind of work done ng life DO NOT use retired)	16b. Kind of Busines	ss/Industry
15-0036 filed within 72 hours after death with the Maryland 1 Hygiene clother than "natural", or items 23a or 28a-fahe i, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12 HANO	MAN	SEIF	EmployED
21215-0036 Uld be filed within 7 Mental Hygiene marked other than	Be	17. Father's Name (First, Middle, Last)  ROBER +  19a Informant's Name/Relationship (Type, Print)  ROBER +  PECTY RIES SE 2/01 B  20a Method of Disposition  20a Method of Disposition	R PAULINE	dle, Maiden Surname)  Mox	rton
MD 2121 dd 2 should be f uth and Mental m 27 is markee aumatic event,	의	19a. Informant's Name/Relationship (Type, Print)  Robert Percy Ryles Sk 2/07 B	(Street and Number or Rural Route E/Air RD BA	Number, City or Town, St.	ate, Zip Code)
		20a Method of Disposition  20b. Place of Disposition (Name crematory or other place)	(Street and Number of Rural Route  E/Air RD BA  of cemetery,  Date	20c. Location - City	or Town, State Mp
E C 0 E L		4 Donation 5 Other Specify: GAYY Son FoR E3 21 Signature of Funeral Service Licensee	$ \begin{array}{cccccccccccccccccccccccccccccccccccc$	6 OW:NE	5 Mills
Baltil permit Departm Importa		Sulf Aw called full 22. Name and A Ph.11. P. 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of	A WEATHERTORD	F/S BAHO	mp 2/2/3
Physician /Modical	ľ	23a Parf I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line.	dying, such as cardiac or respiratory	y arrest, shock, or heart	Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Mixed alcohol and narcotic (mor Due to (or as a consequence of):	phine) intoxication		Death
· · · · · · · · · · · · · · · · · · ·	7	Sequentially list conditions, if any, leading to immediate bulleto (or as a consequence of):			
1	Examine	cause. Enter Underlying Cause (Disease or injury that initiated			
executed an and all - transit	EX.	events resulting in death) Last Due to (or as a consequence of).			
O, e be sicii	edical	X UNPENDED #23a,27,28a-f, perME, g	862, 12/27/06 TT		
5876 rtificate ling phy	/sician/M	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy	23d Date of delive Month	Day Year
Division of Vital Records, P.O. Box 6876 rat or Attending Physician: The law requires that the death certificate is after death all Director: After this certificate has been signed by the attending phylical in by the funeral director, page 2 should be detached for use as the	ysici	4 Pregnant at time of death 5 Other (Special Pregnant At time of death 5 Other (Special Pregnant At time of dea	(y)		
O. E hat the ed by the etached	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying of		Old tobacco use contribute	
ls, P quires t en sign				Yes 2 ✓ No 3 F Was an 24b Were	autopsy findings available
COFC s law re s has be	Completed		a	autopsy prior performed? peath	to completion of cause of ?
tal Reco	ادہ		6.Place of Death (Check only one)	res 2 No 1 ✓	Yes 2 No
Vita	70 B	examiner? 1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DC			ther:
nn of nding Pl th : After e funeral		1 Natural 5 Dending (Month, Day, Year)	3c. Injury at Work? 28d. Description 28d	ribe how injury occurred	
visio	ficat	2 Accident Investigation   Fnd 12/9/2006 Fnd 3:17 pm   28e. Place of Injury - At home, farm, street, factory,	office building, etc 28f, Locati	on (Street and Number or	Rural Route Number, City
Div spital o	Certification:	4 Homicide determined (Feithd: residence	Baltim	wn, State) 2107 Bellore, MD	air koad
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certifican within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stetled.			
5 1 × 1 0	Me		License number	29d Date signed (	
		XI ((XV))	O.C.M.E.	December 10,	2006
10			, Baltimore, MD 21201		
Sta Regist	ate rar		E		
DHMH 17 Rev 1/20		ORIGINAL			

			For State Registrar		State of	Maryla			rtment of H				gienę No.,	00	6	39569	
	Av		1. Decedent's Name (First, Midd	lle, Last)								2. Date of Dea	ith		1./	3. Time of Death	•
	Physici /Medic		WILLIAM EMORY ST	INCHC	OMB Jr.							Month DEC. 6	Day 20	06	ear	1935 M	
	Examir	1.00	4a. Facility Name (If not institution	on, give s	street and num	nber)			4b. City, Town, or	r Location	of Death			county of I	Death		-
		0	6 WENDOVER RD.						GLEN BUF	MIE				ANNE A	A DI INI	DEI	
	Funeral		5. Social Security Number	6. Sex		7. Age (In y	rs. last birt	hday)	If Under 1 Year	If Under		8. Date of Birtl	7		Birthp	lace (State or Foreign	-
	Director		213.28.9725	1)(3)	M 2□F	76	1	Yrs.	Months Days	Hours	Min.	(Month, Day		0 1	Coun 4D	itry)	
	ס		Usual Residence of Decedent							1		001. 2	.0 9 1 2 3	0 1 .	10		_
	ylan		10a. State 10b. Count	У		10c.	City, Town	or Lo	ation						1	0d. Inside City Limits	
	ith the Marylar or 28e-f show	Director	MD ANNE	ARUNI	nFi		GLEN BU	IRN H	=							1 ☐ Yes 2√√√ No	
	1 the	re	10e. Street and Number	71110111	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		alli be	21(1)	10f. Zip Code				10g. Citiz	en of Wha	t Cour	itry?	-
	23a o		6 WENDOVER RD.						21060				USA				
	Iteme 2	Jer	11. Marital Status		12. Was Dece	dent Ever in	n U.S.	13. V	Vas Decedent of H	ispanic Or	gin? (Spe	cify Yes or No-			Americ	an Indian,	-
Maryland 21215-0036	± 2 €	by Funerai	1 ☐ Never Married 2 ☐ Ma 3(☐) Widowed 4 ☐ Divorce		Armed For 1 DYes If Yes, Giv Year or Da	2 □ No e			Yes, specify Cuba  ☐ Yes ②  ☐ No	in, Mexicai Specify:		Rican, etc.)		Black, \ Specify: \			
ŏ	"natural",		15. Decede	nl's Edu			16a.	Deced	ent's Usual Occup	ation			16h Kin	d of Busin	ess/Ind	dustry	-
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an	2 should be i and Mental I is marked or reumatic eve	Be	WILLIAM E. CTINO	LOOME	C									,			
$\geq$	d Me	은	WILLIAM E. STINCH 19a. Informant's Name/Relation				10h	Modie	g Address (Street			SCHULTZ	- City	T 04-	40.75-	0-4-1	_
Z Z	12 s h an 7 is		CATHY E. HASENEI	Jinp (1)	DAUGHTE	P	-		RTH POINT				21219	TOWN, Sta	ite, zip	Code)	
	s 1 and 2 f Health item 27 i	-	20a. Method of Disposition		DAOGITIE				sition (Name of	10., L		ale		ntine Cit	T.		_
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	Physician		Immediate Caus (Final disease or condition		0.572.5	M	2-1-5	8.1						)		Onset and Death	
	/Medical		resulting in death)		Due to (	or as a cons	sequence	of):	ne sour	aci	ony	Card	166	1185	-	1 month	-
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687	phys phys s the	dicai			J												
×	eath certific attending p	Physician/Me	IF FEMALE:	2	3c. If yes, out	come of pre	anancy										_
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?		1☐Live bi	irth 2 🗆 F	etal death		Ectopic pregnancy	,			2.	3d. Date of Month		ry Day Year	
	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9☐ Unkno	ant at time o	or death	2	Other (specify)							,	
P.O.	that the ded by the detached		Part II. Other significant condit	ions cor	atributing to de	ath but not	roculting in	thous	doshina on una au	oo io Dart I		230 Did to	haces us	a acalab.	to to th	e cause of death?	-
Ś	ires t signe d be d	b	Tartin omor significant conditi	+	1 Y	3	resulting in	i tile ur	derlying cause givi	en in Farti	•						
oro	w requires been sign should be	ted	ruenc Call	The	TAM ICE	wid						Y⊠ Y	es 2	INO 3	_ Prob	ably 4 Unknown	
Ö	as b	Completed										24a. Was a autop		24b. Wer	e auto	psy findings available inpletion of cause of	
Œ	The page	Ю										pertor	med?	dear	th?	2 DNo	
Vital Records,	Attending Physicien: The law requires that the death certificate relath. r death. sctor: After this certificate has been signed by the attending phys the funeral director, page 2 should be detached for use as the	BeC	25. Was case referred to medic	al						26. Place	of Death	(Check only or	-				*
	ysic is ce direc	To	examiner? 1 ☐ Yes 2 No	H	lospital:	npatient 2	2 🗆 ER/Out	tpatien	3□ DOA Othe	er: 4 □ Nu	irsing Hon	ne 5 Resid	ence 6	Other (	Specifi	/)	_
Ö	ding Ph h. After th tuneral		27. Manner of Death		28a. Date o	of Injury h, Day Year	28b. T	ime of	28c. Injun Worl			8d. Describe h				<u></u>	-
0	th: Aft	atio	1 Natural 5 Pend 2 Accident inves	ing tigation	(MOIN	II, Day 1 ear	"	njury		k? Yes 2 ☐	No						
Division of	Attendi death.	Certification:	3 ☐ Suicide 6 ☐ Could	not be	28e. Ptace	of Injury - A	At home, fa	rm, stre	eet, factory, office		2	28f. Location (S	treet and	Number o	or Rura	I Route Number,	-
Ö	afte Dire	erti	4 Homicide deter	milou	buildir	ng, etc. (Spe	ecity)		7.			City or Tow					
	spita ours ours fille		29a, Certifier 1 Certify	ina Phys	sician: To the	hest of my	knowledge	death	occurred at the tin	ne date ar	id place, a	and due to the o	21150(5)	nd mann	25.20.00	ntod	-
	To the Hospital or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical	(Check only 2 Medica	I Exami	ner: On the ba	asis of exam	nination and	d/or inv	estigation, in my o	pinion, dea	th occurre	ed at the time, o	date and	lace, and	due to	the cause(s)	
	o thin o thin o thin	Me	29b. Signature and title of certifi	er			1		29c. License	e number			29d. Date	signed /A	Aonth .	Day, Year)	-
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	(		( ) hor	76	1/ (1-		/		10	5/	5	/	Me	ent	CL.	1,2006	_
	Y		30 Name and address of perso	n who co	mpleted caus	e of death (	Hem 23a) (	Туре,	Print)	A 1	~	01	10			12	
			15 USSUNG	S	)a ju	uns	0 3	0 5	Mosc	3)-02/	MY	19,0	5012	wed.	1,5	el-1,061	
12	Sta		31. Date filed (Month, Day, Yea		32. R	egistrar's Si	-		`	-					J		
	Regist	ar	DEC12	2006	Here	W.	K A	book	0								_
DH	MH 17 Rev 1/2	2001					7		-								

ORIGINAL

39570

			For State Registrar	State of Marylan		rtment of F tificate of			iené UUO	33310
			Decedent's Name (First, Middle, Last	st)				2. Date of Deat	h	3. Time of Death
	Physicia /Medic		WILLIAM /	Suu	IVAN			Month NOVEMBO	Day Year 54 26 2006	4:00 PM
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of Deat	h
			621 N. POT	OMIC ST		IS A LT	I MARE If Under 24 Hrs.	O Date of Bird	1/4	
	Funeral Director		5. Social Security Number 6. S 213-12-9385	ex 7. Age (In yrs.	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, TAK), 2	Year) 9. Bin	hplace (Stete or Foreign
			Usual Residence of Decedent	27				JAW, 20	5,774	7 - 1
	ryland		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	8a-f.s	Director	$MD \setminus M/$	A B	ACTI	MORE		1		1 Yes 2 No
	with the	Dire	10e. Street and Number	- 11:00		10f. Zip Code	/	10	Og. Citizen of What Co	untry?
	death with the Maryland ms 23a or 28a-f show rmast be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. V	Vas Decedent of H	dispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	
o			1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No If Yes, Give	If	Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
200	72 hours after natural', or Ite	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1			Specify: U	HITE
ה ה	"nate	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced	ent's Usual Occup kind of work done	ation during most of worki d)	ing	16b. Kind of Business/	Industry
7	withii Bne. than	dino	Elementary/Secondary(0-12)	College (1-4or 5+)	Boi	1 )	PER		OFFid	F
ם פ	illed Hygid other	Be C	17. Father's Name (First, Middle, Last)	,	1000	/	18. Mother's Name	(First, Middle, A		
Jan	should be nd Menta marked imatic ev	To B	UNI	(Docen)			UN	KNOU	010	
a	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (	· · · MRJ	19b. Mailin	g Address (Street	and Number or Rura	I Route Number,	City or Town, State, 2	Tip Con 202
≥ m̂	C = 01 -		DEPI. OF	ABIFE SCHU	10. A	EAL	NEAT	37 #	300 BAC	TO MD.
0	9 = 5		20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State		sition (Name of patory or other plan		1	20c. Location - City or	Town, State
altim	permit. Pag Department Important: any injury once.		*4 □ Donation 5 □ Other (Specification of Funeral Service Licer		PRISO	Nam and Addre	>1 2	006	13440:	CE HP
מ	Deparimination of the paramiter of the p		21. Signature of Fulleran Service Elder	oll and land	. (	KANIN	1 - 1 2	829/1	PREED	517 916
			23a. Part1. Enter the disease or com shock, or heart failure. List only	plications that caused the deat	h. Do not ente	er the mode of dyir	ng, such as cardiac o	or respiratory arre	est,	Approximate
	Physician		Immediate Cause (Final							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. CORONARY A  Due to (or as a conseq		13136750				
	Examiner		Sequentially list conditions,	, HYPERTENS	Noi					
7	Po iii	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):					
V	and I-trans	xam	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):				-	
Ď.	licate be executed physician and s the burial-transit									
0/90	ficate be physicials ts the bur	edicai		d						
X D	leath certifi attending I for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy	Estacia araggana			23d. Date of del	ivery
מ	0 0 0	Physician/M	in the past 12 months? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	4☐ Pregnant at time of d		Ectopic pregnancy Other (specify) _	y 		Month	Day Year
r S	at the d by the etach	Phy	9 Unknown		Maria de Maria		1. 8	OO Did to	acco use contribute to	the server of death?
Š,	law requires that the de as been signed by the a 2 should be detached	by	Part II. Other significant conditions of	S CHRONIC RE	-				/	obably 4 Unknown
ecords,	requ been should	Completed	STANCE BURGETE	5 CHIODNIC M	J. CORT	IN SU FFI C	04-[			
e L	The faw te has I	mpi						24a. Was ar autops perform	y prior to d	topsy findings available completion of cause of
VIII		e Co	25. Was case referred to medical				26. Place of Death			2 No
		0 8	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	3 DOA Ott			nce 6 Other (Spe	cifv)
101	ding Phys h. After this funeral di	T:U	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui			w injury occurred	.,,
0	endir aath. or: Af he fu	atic	1 Natural 5 Pending 2 Accident investigation	1	,,		Yes 2 □ No			
DIVISION	or Att fter d lirect in by t	ertification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At hi building, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location (Sti City or Town	reet and Number or Ru , State)	ıral Route Number,
_	pital ours a erai C	0	29a, Certifier 1 Certifying Ph	ysicien: To the best of my kno	udodgo doath	accurred at the ti	mo date and place	and due to the ca	usels) and manner as	etatod
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	edicai	(Check only 2 Medical Exer	niner: On the basis of examina and manner stated.	ition and/or inv	estigation, in my	opinion, death occurr	ed at the time, da	ite and place, and due	to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	1		29c. Licens	se number	29	9d. Date signed (Monti	h, Dey, Year)
			James II	nah 1	MD	D62	2032	N	OVEMBER	27 2006
	141		30. Name and address of person who	completed cause of death (Item	n 23a) (Type,	Print)	,			
	1 ' '		JENNIFER HAY,	4541 5505 H	DPKINS	BAYVIE	W CIRCU	E, BAL	TIMORE M	D 21224
	Sta Registi		31. Date filed (Month, Day, Year)	completed cause of death (Iter	F. Ace	MED !				
	3		DLO T ~ ~ ~	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 2006 3:24 Barbara H. Stewart Dec. 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Aug. 30, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours 1 □ M 2 1 XF 426-34-5963 81 1925 Mississippi Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla pepertment of Health and Mental Hygien's in Pratural," or Items 23a or 28a-f show Important: If Item 21 is marked other than "natural," or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 1 ☐ Yes 2 TNo Director Baltimore Sparks 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21152 USA 17 Rainflower Path Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify þ 3 X Widowed 4 ☐ Divorced white white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Education 4+ Guidance Counselor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Unknown Eleanor Kelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Janelle Stewart - Daughter 14217 Quail Creek Way Sparks, MD\_21152 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Dec. 11, 06 Baltimore, MD 21. Signature of Funeral Service <sup>22</sup> Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician: after death. within 24 hours a

To the Funeral C

the State

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

(Item 23a) (Type, Print)

Baltono 2,204 . Charles St. Selfe 209, 6565 N

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred at the cause(s) and manner as stated.

29a. Certifier

Medical



Registrar

		For State Registrar		State	of Marylan	d / Dep <i>Ce</i>	artment <i>rtificate</i>	of He	ealth a Death	and Me		giene Reg. No.			39572	
	-											ath			3. Time of Death	
Physi		Emanuel Spadaro									Month Decemb	Day			10:48 a <sup>M</sup>	
/Med Exam		4a. Facility Name (If n	4b. City, Town, or Location of Death				Decemb	ecember 12, 2006   1			20.10_4					
LAAII	illei	Brighton Gardens of Pikesville						Pikesville					Baltimore			
Funera		5. Social Security Nun		. Sex	7. Age (In yrs. last birthday)			If Under 1 Year If Under 24 Hrs.			8. Date of Bir	th	9 Birtholage (State or Foreign			
Directo		556-09-330	)4	1 <b>X</b> M 2□ F	93	Yrs.	Months	Days	Hours	Min.	Month, Da Jan. 1	19, rear)	13	Count	y) Italy	
		Usual Residence of D														
ylan how		10a. State 1	0b. County		10c. Cit	y, Town or L	ocation							10	d. Inside City Limits	
a Ma	Ş	MD	Ba1t	imore	more P			ikesville					1 [ Yes 2x No			
h th	ie	10e. Street and Numb	er				10f. Zip 0	Code				10g. Citi	izen of What	t Count	ry?	
th will	a	1840	Reiste	rstown R	own Road			21208				Ţ	U.S.A			
tore, Maryland 21215-0036 ges 1 and 2 should be tiled within 72 hours after death with the Maryland it of Heelith and Mental Hygiene. If item 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, the Medical Examinar must be natified at	Funeral Director	11. Marital Status		12. Was Dec	12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Puc			gin? (Spec	Specify Yes or No- rto Rican, etc.)		14. Race - American Indian, Black, White, etc.			
after or its	豆	1 Never Married	2 Marrie		2 XNo		1 Yes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,	ilouri, oto.)		Specify:	viille, e		
21215-0036 d within 72 hours atlagione. Then "natural", or then "matural", or the Medical Exami	Completed by	3 ☐ Widowed 4	Divorced	Year or Dates:			12 103 22 110 Specify.						White			
5-C	ete	(Specify	5. Decedent's only highest	Education grade completed)		16a. Dece (Give	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)			t of workin	g	16b. Ki	. Kind of Business/Industry			
aryland 2121( should be filed within I and Mental Hygiene. • marked other than " umatic event, the Mac	ig.	Elementary/Second			College (1-4or 5+)						-	_	Schlitz Brewery			
2 week	Š	12				Salesman										
Dd fit d out	Be	17. Father's Name (First, Middle, Last)							18. Mothe	r's Name	(First, Middle	, Maiden	Sumame)			
should to marked umatic a	မ	Biagio Spadaro					Lena A					ro1a				
Maryland d 2 should be file th and Mental Hy t? Is marked oth		19a. Informant's Nam	e/Relationship	(Type, Print)		19b. Maili	ng Address (	Street a	nd Numbe	er or Rurai	Route Numb	er, City o	r Town, Stat	te, Zip	Code)	
1 and 1 and Heelth	1	_ JoAnne Bo	ortz	Daugl					Fari						21117	
es 1	1	20a. Method of Dispos 1 Burial 2 X		□ Pomoval from	1 /	Place of Disponentery, cre	osition (Name matory or oth	e of er place	)	Da	ate	20c. La	cation - City	or Tov	vn, State	
Page nent o		4 □ Donation 5				rroll	Cremat	ion	D	ec. ]	13, 06	F	Hampst	ead	, MD	
Baltimore, M. permit. Pages 1 and 2 Depertment of Heelth a Important: If them 27 is any Injury or other tre	i I	21. Signature of Fune	ral Service Li	censee			2. Name and	Andrew Market Market April 1	s of Facilit	у	11824				•	
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By Secure 2 Physician and Physician and the burial-transit	Examiner	23a. Part1. Enter the disease, or complications that mused the death. Do not enter the mode of dying, such as carriac or respiratory arrest.  Approximate Interval Between Onset and Death  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):														
cords, P.O. Box 68760, w requires thet the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Completed by Physician/Medical	d					ath 3 □Ectopic pregnancy 5 □ Other (specify)					23d. Date of delivery Month Day Year				
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Of V Physic this can dire	ပု	1 ☐ Yes 2, ☑No	0	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 DOA	Othe	r: 4 🗆 Nu	rsing Hom	e 5∐ Resi	Residence 6 Other (Specify)				
n C ng P fter t	Ë	27. Manner of Death	5 Pending	28a. Date (Moi	of 28	28c. Injury at Work?			28d. Describe how injury occurred							
VISION Attending r death. octor: Alter	atic	2 Accident	investiga	4					Yes 2 □ No							
in the second	Certification;	3 Suicide 4 Homicide	6 ☐ Could no determin	ed 289. Plac build	28e. Place of Injury - At home, farm, st building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number City or Town, State)					
he Haspital in 24 hours e he Funeral I	Medicai	29a. Certifier (Check only one)  Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2   Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													ited. ine cause(s)	
To the within 2 To the complete	2	29b. Signature and tit	$\sim$	29c. License number					,	29d. Date signed (Month, Day, Year)						
10		30. Name and address person who completed cause a death (Item 23a) (Type, Print)  Having Riskly And Sheet 2/136												2, 2006		
Spanis		31. Date filed (Month,	Day Vocal	1 (1)	Registrar's Signa		1/7/00	· ·	reev		211	54	3			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 39573 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dorothy Catherine Stack **Physician** December 10° 2006 Year 1:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Joseph's Hospital Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 12, 1915 5. Social Security Number 7. Age (In vrs. last hirthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ **y**F Months Days Hours Min 91 218-01-1011 Mary Tand Director Usual Residence of Decedent 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Baltimore Baltimore 1 ☐ Yes 2 No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4339 Garland Avenue 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Boehn Barbara Boehl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is Dennis J. Stack/Son 4339 Garland Avenue Baltimore Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: if ite any injury or ot once, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/12/06 Towson Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc 5305 Harford Road Baltimore Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atheros lenot. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner hypertersin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): physician use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown icate has been significate has been significant. 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760.

altimore, Maryland 21215-0036

Hospital or Attending Physician: n 24 hours after death.

Ie Funeral Director: Af filled in by within 24 hou To the Fune completely fi To the I

> State Registrar

31. Date filed (Month, Day, Year) DEC 1 2 2006

29a. Certifier

one)

(Check only

29b. Signature and title of certifier

mier-0000

Migh-Door Kither 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

86)

29d. Date signed (Month, Day, Year) 2-11-01

Swallow, Julia

			1 - For Amend #5	Per	State of Ma FH G862	12/I	d/Bep Ce	artmen h <i>rtificat</i>	it of H e of L	leaith a D <i>eath</i>	ind Me	ental F	lygien Reg. N	200	36	39574
п	Physici	an	1. Decedent's Name (First, Mid	dle, Las	<i>t</i> )							2. Date of Month	Death Da	av	Year	3. Time of Death
	/Medic		Julia Swallow									Decen			006	4:00 P M
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no	ages ant of t: If it		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other				emetery, cre			1	0.10.1	0.6			,	
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ñ	Depa Impo eny I		Michael J.	<b>₹</b> 1	agle		10	emmon	n Fur	neral	Home	of I	ulan	ey V	alley	, Inc.
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		For State Registrar	St	tate of M	larylan	d / De <i>C</i>	partment <i>ertificate</i>	of Hea	alth and <b>I</b> e <i>ath</i>	Mental H	ygiene Reg. No		16	395	575
Discussion!		1. Decedent's Name (First, Middl	e, Last)							2. Date of E Month	Death Day	v V	ear	3. Time of E	Death
Physicia /Medic		Hi1da	Ε.	•		Schoe	lkopf			Decemb				6:00	2AM
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		Mays Chapel Ri	dge	_				Timor				Ва	lti	more	
Funeral		5. Social Security Number	6. Sex 1 ☐ M		ge (In yrs.		Months		Under 24 Hrs. Hours Min.	8. Date of E (Month, I	Birth Day, Year)	9.	Birthpl Count	ace (State or	Foreign
Director		217-01-5901	1 10 101	- A.	88	Yrs.				Jan. 1	, 191	18	Mar	yland	
and w		Usual Residence of Decedent  10a. State 10b. County			10c. Cit	y, Town or	Location						10	d. Inside City	Limits
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alth alth a		Cynthia Taylor,	/Niece	:		122	251 Rou	ndwoo	d Road	#401 T	imoni	lum, M	D 2	1093	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Inmportant: I flem 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		oval from State	20b. F Du I	Place of Discemetery, of aney	sposition (Namerematory or of Valley L Garde	e of herplace)	-	Date nber 12	20c. Lo	ocation - Cit	y or Tov	vn, State	
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Physician ledical Examine	1	1. Decedent's Name (First, Middl Willie Savag	e,Last)						2	. Date of Dear		3. Time of Death 1030 hrs
لامنع		4a. Facility Name (if not institutio	n, give street and	number)	4	b. City, To	,	ocation of		. 10 10 11 15 01	4c. County of D	reath
Funeral	Ļ	200 block Preston Str		7. Age (In yrs.	last birthday)	Baltimo If Under		If Under :	24Hrs.	8. Date of Bir	th(MM/DD/YYYY) 9	Birthplace (State or 1)
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any		Usual Residence of Decedent 10a. State 11nk 10b. County		10c. Cit	y, Town or Location	on .	-					10d Inside City Limits
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with the	<u>-</u>	11. Marital Status	12. Was [	Decedent Ever in	U.S. 13. Was	Decedent	of Hispa	anic Origin	? ( Spec	cify Yes or No	USA - 14. Race - A	merican Indian, Black,
or item	runerai		arried Armed	Forces s 2 No	unk If Ye	s, specify			Puerto R	ican, etc.)	White, et	tc.
urs afte	≥ -	3 Widowed 4 Div  15. Decedent's Education (Spe	orced If Yes, Give or Dates: cify only highest g		_	Yes 2 s Usual Or	_		nd of wo	rk doneunk	Specify: 16b. Kind of Busine	black ess/industry unk
66 n 72 ho uan "na ical Ex	) ete	Elementary/Secondary (0-12) unk		e (1-4 or 5+)	during mo	st of worki	ng life. D	OO NOT us	se retire	d)		din
be filed within 72 hours after death with the Maryland ntal Hygien. First, other than "natural", or items 23a or 28a-f 5th First, the Welts I Examiner must be notified at once	ĘL	17. Father's Name (First, Middle,	unk Last)			- <del>un</del>	€ 18	.Mother's	Name (f	First, Middle, I	Maiden Surname)	-unk
21215-003 uld be filed withi Mental Hygiene, marked other the	g [	Willie Georg		<u> </u>	1 20 300			C	eles	tene	Savage	
2 sho	2 [	19 Antomani's Natice Relations O.C.M.E.	Littlejo	hn	19b, Mailing 20 111 1	)567	Lowi	ield	Dr. alti	Geru	nber, City or Town, S PARTOWN, MI MD 21201	0. 20874
and and tra	Ī	20a. Method of Disposition  1 Burial 2 Cremation	n 3 Remova	20b	. Place of Disposit crematory or oth	ion (Name				Date	20c. Location - Cit	y or Town, State
. <u>=</u>	ļ	4 Donation 5 X Other S	pecify: in s		22 N	ame and A	ddress o	f Facility				
Balti permit Departi Import injury		21. Signature of Euneral Service ROTIAL	5 Wade,	Directo	r Sta Bal	te Ar timor	ator	ny Bo MD 2	ard 120	655 W	. Baltimon	re Street
Physician /Medical	ľ	23a. Palt I. Enter the disease for failure. List only one cause	on each line.						diac or r	espiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		rosclerotions a consequence	c cardiova: of):	scular	dise	ase_				Oeatri
	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consequence	of):							
	틹	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	is a consequence	of):							
ecuted and transit			d									
60, ate be ev hysician e burial	Jedic Jedic	X UNPENDED	AMENDE	#23a,PI	I.27.perME	<b>.</b> g862	. 12/	14/06	ТТ		23d. Date of del	NO.
Sox 6876 leath certificat e attending ph for use as the	ian/k	23b. Was decedent pregnant in the past 12 months?	he 1 Liv	e birth egnant at time of	2 Fet	al death		Ectopic p	pregnanc	су	Month	Day Year
Box e death c the atten ed for us	Physician/Medical	1 Yes 2 No 9 Uni		nknown	oeatri 5 Oth	er (Specif	y)					
	Dy P	Part II. Other significant condit Chronic alcoh		g to death but not	resulting in the u	nderlying c	ause giv	en in Part	I.	-		e to the cause of death?  Probably 4 ✔ Unknown
rds, require been sig	Completed	andic alcor	ior abase							24a. Was	an 24b. Wer	e autopsy findings available
Records, The law require icate has been si page 2 should b	e l										rmed? deat	r to completion of cause of th? Yes 2 No
Vital Rechysician: The this certificate al director, page	Re Re	25. Was case referred to medica examiner?	Hospital:	] In all and 2	ER/Outpatient		10	f Death (C				
n of V ing Phys After thi	앍	1 V Yes 2 No 27. Manner of Death	28a. D.	Inpatient 2 ate of Injury onth, Day, Year)	28b. Time of Ir		`	at Work?			Residence 6 🗸 0	other; Scene .
Division ral or Attendion rs after death.	jatio	1 X Natural 5 Peni 2 Accident Inve	ding stigation					s 2 N				
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completeld in by the	ertification:		Id not be rmined (Spec		home, farm, stree	t, factory, c	mice bui	laing, etc.		or Town, S		r Rural Route Number, City
To the Hosp within 24 hou To the Fune completely fi	ပ -	29a. Certifier 1 Certifying P									se(s) and manner as	
To th within To th comp	<u>8</u> [	one) 2 Medical Exa 29b. Signature and title of Certific	and manne	er stated.	and/or investigati		License		urred at i	ine time, date	and place, and due	(Month, Day, Year)
			00/1-	1/			O.C.M	.E.			November 24	
		30. Name and address of persor Jack Titus MD. De	, -	•		n Street	Baltir	more M	ID 212	01		
Sta	te	31. Date filed (Month, Day, Year)		. Registrar's Signa		de la	,	, 141				

			For State	State of	f Marylan		rtment of He			0.0	0.0	00
			Registrar  1. Decedent's Name (First, Middle, L	act)		Cer	lilicate of D	eatri	Re 2. Date of Death	g. No.	Ub	3 3 5
	Physici: /Medic	_		Milda	M. Stir	nnett			Month December	7, 20		11:28P M
1	Examin	er	4a. Facility Name (If not institution, g. Alice Manor Nurs				4b. City, Town, or L	ocation of Death		4c. County	of Death	
				Sex Sex	7. Age (In yrs.	last birthday)		If Under 24 Hrs.	8. Date of Birth			
	Funeral Director			1□ M & F		77 Yrs.	Months Days	Hours Min.	(Month, Day, March 8,	<sup>Year)</sup> 1929	Gua	place (State or Foreign otry) atemala
	D.		Usual Residence of Decedent									
	arylan show	_	10a. State 10b. County		10c. Cit	ty, Town or Loc						10d. Inside City Limits
:	8a-f s	Director		/A			Baltimore					1√PYes 2□No
	or 2		10e. Street and Number				10f. Zip Code	04.4	10	g. Citizen of V		
	sath v	Funeral	3906 Falls Road	12 Was Deco	edent Ever in U	I		211	onify Von or No	14 Bac	US e - Ameri	oA can Indian,
	ter d	Fun	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Married</li></ul>	Armed Fo	rces?	7.0.   10. <b>!</b>	Vas Decedent of Hisp FYes, specify Cuban	, Mexican, Puerto	Rican, etc.)		k, White,	
0000-01717	urs a al", o	by	<b>X</b> Widowed 4 □ Divorced	1 □ Yes If Yes, Giv Year or D	ve ates:	1	X Yes 2☐ No	Specify:		Specify	· F	Mispanic
	within 72 hours after death with the Maryland lene. Then "netural", or Items 23e or 28a-f show the Medicel Examiner must be notified at	Completed	15. Decedent's (Specify only highest g	Education		16a. Deced	ent's Usual Occupat	ion pring most of work	ina	6b. Kind of Bu	siness/Ir	dustry
1	ithin Je. Mec	nple I	Elementary/Secondary (0-12)	College (1	-4or 5+)		kind of work done du OO NOT use retired)	g		T	1. 1	
4	Hod w Hygien her ti		17. Father's Name (First, Middle, Las	nt)		HOM	emaker	19 Mothor's Name	e (First, Middle, N	In own		ie
mai yiand	abe t ental h ed ol	Be c	Carlos Abela						ica Ovan		10)	
	should nd Me mark matic	ဥ	19a. Informant's Name/Relationship	al Route Number,		State. Zii	Code)					
=	nd 2 alth ar		Zaidy E. Carlson	Baltimore	, Mary	land	21211					
5	of Heal		20a. Method of Disposition			Oc. Location -						
•	Pege nent c		1 ☐ Bunal XXICremation 3 4 ☐ Donation 5 ☐ Other (Spec		State I	tro Cre	natory or other place) matory		/2006	Catons	/ille	, MD
Dalimore,	permit. Peges 1 and 2 should be flied within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If them 27 is marked other then "netural", or items 23e or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral/Service Lic	ensee	Moo	0 1/ B	Name and Address urgee—Hen: 631 Falls	ss-Seitz	Funeral altimore	Home,	Inc.	21 21 1
E			23a. Part . Enter the disease, or co shock, or heart failure. List on	molications that c	aused the deal						Laud	Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	P	rotor	· Ca	lone	Mahry	trita			Onset and Death
-	Medical		resulting in death)	Due to	or as a consec	quence of):	9700		00.70.00	7		
	Examiner		Sequentially list conditions,	b	Look	enve	_ De	ehne				
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a collised	quence of):	Co.	п	2 22			
•	xecur and al-trar	Examiner	that initiated events resulting in death) Last	cl f	or as a conseq	quence of):	an ce		meen		-	
	cate be executed physician and the burial-transit	dical E			De gen	vatr.	- Ja	ut Di	begre			
)	as di	ledi			8							
	iires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		ointh 2□Feta nant at time of d	aideath 3□	Ectopic pregnancy Other (specify)				e of deliv	ery Day Year
	that the led by detact		Part ii. Other significant conditions	contributing to de	eath but not res	sulting in the un	nderlying cause given	n in Part I.	23e. Did tob	acco use cont	ribute to t	he cause of death?
	quires n sigr ald be	d by							1 □ Ye	s 2□No	3 🗌 Pro	oably 4 Unknown
	I he law requires that the te has been signed by the tage 2 should be detached.	Completed							24a. Was an autopsy perform	,   1	Were auto	ppsy findings available mpletion of cause of
	sician: In certificate rector, pag		25. Was case referred to medical					Of Disco of Da-1		□ M6		2 □ No
	ysicia is cert directe	To Be	examiner?	Hospital:	Inpatient 2	ER/Outpatien	Othor	. /	me 5 Reside		er (Speci	fv)
ì	Attending Physician: r death. ector: After this certifica by the funeral director,		27. Manner of Death	28a. Date		28b. Time of Injury	28c. Injury a		28d. Describe ho			**
	endin ath. or: Af he fur	atio	1 Accident 5 Pending investigati	on	,,	,,		es 2□No				
	el or Att	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d Zoe. Flace	of injury - At hing, etc. (Speci	ome, farm, stre	eet, factory, office		28f. Location (Str City or Town	eet and Numb State)	er or Run	al Route Number,
	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying I (Check only one) 2 Medicai Ex	aminer: On the b	e best of my kno asis of examina ner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my opi	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and ma ite and place,	anner as s and due t	stated. o the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	Wan &		m12	29c. License	number 1464	29	d. Date signe	d (Month,	Day, Year)
	3		30. Name and address of person wh	HAPHY	MI S	21 N	Print) ENTAL	N ST 8	inte 3	08 BI	101	MORE MI)
ļ	Sta Registi		31. Date filed (Month, Day, Year) DEC 1 2 20	006 Jan	legistrar's Sign	ature	W					
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**DHMH 16 Rev 6/95** 

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:20 PM Viola N. Smith 6, 2006 December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Catonsville Charlestown Retirement Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 □ M 2 XF 20, 95 1910 Maryland 216-03-9099 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State Items 23a or 28a-f show the Medical Exerciner must be notified at 1 ☐ Yes 🎾 No Completed by Funeral Director MD Baltimore Halethorpe 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1040 Elm Road 21227 United States 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status cernit. Pages 1 and 2 should be filed within 72 hours after or exartment of Health and Mental Hygiene. Intercent: if tiem 27 is marked other than "naturel", or tlen no injury or other traumatic event. If a Martine. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: White Baltimore, Maryland 21215-0036 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Callege (1-4or 5+) Elementary/Secondary (0-12) Garment Tailor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Remeikis Joseph Gabriel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1040 Elm Road, Halethorpe, N. 21227
of Disposition (Name of Date 20c. Location - City or Town, State Gien Haven Edmund J. Smith, Sr. - Son 20a. Method of Disposition N Burial 2 Cremation 3 Removal from State 12-9-2006 Glen Burnie, MD Donation 5 Other (Specify) Mcmorial Park Andress of Facility Ambrose Funeral Home, Inc. ulur - Funeral Service Licenses 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) hence Pnysician /Medical-Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as the burial-transil signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 1 Tes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 20 25. Was case referred to medical examiner? 26. Place of Death (Check onl. one the funeral director, Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 / Homicide n 24 hours af ne Funeral D letely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 2 To the 29d. Date signed (Month, Dey, Year)

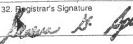
State Registrar DHMH 17 Rev 1/2001

2 augs

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



Calianile MU

**ORIGINAL** 

	State of Maryland /	Depa	artment of Health	and M	ental Hyg	iene		
•	1 - State Registrar	Cei	rtificate of Deat	h	Re	eg. No. 2	106	39580
	Decedent's Name (First, Middle, Last)	-	•		2. Date of Deat			3. Time of Death
n	GEORGE FRANCIS SPINDLER				Month 12	6 Day	2006	4:30 A M
ai er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Locatio	n of Death		4c. Count	y of Death	
43	417 Madingley Road		Linthicum			Anne	Arund	de1
	5. Social Security Number 6. Sex 7. Age (In yrs. last to	irthday)		ler 24 Hrs.	8. Date of Birth (Month, Day,	Voorl	9. Birth	place (State or Foreign
	218-28-6213   <sup>1⊠ M 2□ F</sup>   72	Yrs.	Months Days Hours	s Min.	01-27-1	934	Cou	(mtry) MD
	Usual Residence of Decedent							
_	10a. State 10b. County 10c. City, To	wn or Lo	ecation					10d. Inside City Limits
g	MD Anne Arundel Lin	thic	um					1 ☐ Yes 2 ☒ No
Öir.	10e. Street and Number		10f. Zip Code		1	0g. Citizen of	What Cou	ntry?
Funeral Director	417 Madingley Road		21090			U.S.A		
nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Specan, Puerto	ecify Yes or No- Rican, etc.)		ce - Americack, White,	
Ē >	1 ☐ Never Married 2 ☑ Married 1 ☒ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☒ No Speci	ify:		Speci	<sub>fv:</sub> wh	hite
g D	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		death Marris One and a		-			
ete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during m DO NOT use retired)	nost of worki	ng	16b. Kind of I	susiness/in	ndustry
Completed by	Elementary/Secondary (0-12) College (1-4or 5+)		phic Designer			Adver	ticir	20
ပ္ထ	17. Father's Name (First, Middle, Last)	oraș			(First, Middle, I			<u>-8</u>
o Be	William Spindler				Burns		,	
Ĕ	•	h Mailie	ng Address (Street and Nur.	mber or Bura	al Route Number	City or Town	State Zii	n Codel
	Mr. Gary Spindler / son		7 Gresham La			•		•
	20a. Method of Disposition 20b. Place	of Dispo	osition (Name of			20c. Location		
	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State		matory or other place)	12.0			•	
	4 □ Donation 5 □ Other (Specify) Chesa  21. Signature of Funeral Service Licensee	*	ke Cremation 2. Name and Address of Fa	L		Stever		•
	1 1 / / / / / / / / / / / / / / / / / /		Second Ave		_			•
	23a. Part 1. Energy disease, or complications that caused the death. D	1					2100	Approximate
	shock, or heart failure. List only one cause on each line.	J HOL BIH		0	^			Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	C_	COLORC	tal	Car	ncer		4 months
	Dud to (or as a consequence	e of):						•
_	Sequentially list conditions, frame leading to from conditions.	ou neflect					-	-
ine	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events	0017:						
dical Examiner	that initiated events c	e of):						
ᄪ		,-						
g	d							
Me	IF FEMALE: 23c. If yes, outcome pf pregnancy					004.0		
ian	in the past 12 months?		□Ectopic pregnancy □ Other (specify)				ate of deliv Ionth	Day Year
Completed by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	JL			-			
된	Part II. Other significant conditions contributing to death but not resulting	in the u	inderlying cause given in Pa	art 1.	23e. Did tol	oacco use co	ntribute to 1	the cause of death?
ğ					1 🗆 Y	es 21⊠No	3 ☐ Pro	bably 4 Unknown
etec							***	
d d					24a. Was a autops perfor	n 24b sy	. Were auto prior to co death?	opsy findings available ompletion of cause of
ဒီ					1□ Yes	2 No	1 Yes	25 No
Be	25. Was case referred to medical examiner?  Hospital: Hospital:		Other		(Check only on			
2	1 Inpatient 2 EH/O	Outpatie	11 3 DOA 4 4	Nursing Ho		ence 6 🗆 O		ify)
ion	1 Natural 5 □ Pending (Month, Day Year)	Injury	of 28c. Injury at Work?  M 1 ☐ Yes 2		28d. Describe ho	w mjury occi	med	
cat	2 Accident investigation 3 Suicide 6 Could not be 289 Place of injury - At home	form ct			006 Loophing (C		- h	
it.	4 Homicide determined 28e. Place of injury - At home, building, etc. (Specify)	, w. 111, St	root, lactory, unice		City or Tow	n, State)	ibei ül Mül	ral Route Number,
ద్ద	29a. Certifier 1'☑ Certifying Physician: To the best of my knowled	ne deal	th accurred at the time, date	and place	and due to the o	augo(s) and r	nonnor an	ntatad
Medical Certification:	(Check only one)    Check only one)							
Me	29b. Signature and title of certifier		29c. License numbe	er		9d. Date sign	ed (Month	, Day, Year)
-	Ma + C · c		> 1.1	110		10 1	110	(-
	your work mo	. /~	1 246	110		12/	610	φ
	30. Name and address of person who ampleted cause of death (Item 23a	i) (Type,	Print)	2 /	u ther	110	iNi	1 21003
	31. Date filed (Month, Day, Year) 82. Registrar's Signature	41	YOUR	UI L	ulher	VIIIC	1-1	0 21073
			i i					

Registrar DHMH 17 Rev 1/2001

State

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

**ORIGINAL** 

			For State	State o	f Marylai		artment <i>rtificate</i>			nd Me		-	2000	2.0	501
, sta			Registrar  1. Decedent's Name (First, Middle	, Last)			imoate	, 0, 1		2	Date of Dea	Reg. No	. 000	3. Tir	ne of Death
	Physicia		Ene-Liis Silbe	rberg						D	Month ecembe	r 9	2006 y	5:	20 A M
	/Medic Examin		4a. Facility Name (If not institution	give street and nu	mber)		4b. City, T	own, or	Location of				. County of Dea	th	
AK.			Montgomery Hosp						ille				Montgo		
	Funeral Director		5. Social Security Number 579–66–7886	6. Sex 1 ☐ M 2X F	7. Age (In yrs 67	. last birthday, Yrs.	If Under 1 Months	Days	If Under 24 Hours	Min. N	Date of Birth (Month, Day ovenber	h /, Year) 19,	1939 9. Bir	thplace (Si ountry) Es	tate or Foreign tonia
	pu »		Usual Residence of Decedent  10a. State 10b. County		100.0	ity, Town or L	agetion								
	faryla shov	j.			100.0										de City Limits Yes 21 No
	the N 28a-i notifi	Director	Maryland Mont  10e. Street and Number	gomery		51	lver S		ng			10a. Cit	tizen of What Co	ountry?	
	n with	Ē	3116 Gracefield	Road, An	artment	т-18			904				ted Sta		
	death ms 2	ner	11. Marital Status	12. Was Dec	edent Ever in l		Was Decede			n? (Specif	y Yes or No- can, etc.)		14. Race - Ame	erican India	ın,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced	Armed Fo ed 1 ☐ Yes If Yes, Gi Year or D	2 <b>]</b> € No ve		1 ☐ Yes 2		Specify:	Puerto Ric	can, etc.)		Specify: White	ie, etc. iite	
9	2 hou atura cal E	ted	15. Decedent	's Education		16a. Dece	dent's Usual	Occupa	ation			16b. K	ind of Business		
21215-0036	thin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	College (	1-4or 5+)	1	kind of work DO NOT use			of working					
7	led wi lygien ner th			5+		P	harmad	cist					harmacy		
Maryland	d be fill ntal H ed otl	Be	17. Father's Name (First, Middle, Albert Rammul	Last)					as Mothers	•	First, Middle,	Maiden	Surname)		
Ž	should nd Me mark matic	မှ	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Maili	ing Address				Route Numbe	er. City o	or Town, State,	Zin Code)	
Š	alth a 27 is er trau		Hugo V. Silberb	erg/Son									k 10968	, ,	
ore,	es 1 a of He fitem rothe		20a. Method of Disposition 1 ☐ Burial 2 ဩCremation	3 Demoval from		Place of Disp cemetery, cre MON	osition (Name	e of		ecemi			ocation - City or	Town, Sta	te
Ĕ.	Pag ment ant: I		4 ☐ Donation 5 ☐ Other (S	pecify)		remato	rium,	Inc	• i L	0, 20		Bet	hesda,	Mary1	and
Baltimore,	permit Depar Import any In		21. Signature of Funeral Service	Licensee	м01	2 B 1473 B	2. Name and etheso etheso	d Addres la-C la.	ss of Facility hevy ( Marv1a	Rober Chase and 2	t A. 1 08[4-3	Pump 1501	hrey Fu 557 Wis	nera consi	L Home, n Ave.,
	3 (27)		23a. Part1. Enter the disease, or shock, or heart failure. List	omplications that only one cause on a	caused the dea	ath. Do not er	iter the mode	of dyin	g, such as ca	ardiac or r	espiratory ar	rest,		Approx	l Between
q	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. Ch	ronic I	ymphoi	d Leuk	kemi	а					Unset	and Death
5.	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):									
31		e.	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conse	quence of):								ļ	
	outed and id	dical Examiner	Cause (Disease or injury that initiated events	C.											
Ő,	icate be executed physician and the burial-transit	EX	resulting in death) Last	Due to	(or as a conse	quence of):									
68760,	cate by	dica		d							·				
			IF FEMALE:	23c If yes ou	tcome pf pregi	nancy									
.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐Live	birth 2 Fe nant at time of	tal death 3	□Ectopic pre						23d. Date of de Month	livery Day	Year
Ö.	t the c by the achec	hysi	9 ☐ Unknown	9□ Unkn	iown										
S, F	es tha gned be det	by P	Part II. Other significant condition	ns contributing to d	leath but not re	sulting in the i	underlying ca	use give	en in Part I.		23e. Did to	bacco	use contribute t	the cause	e of death?
ord	w requir been si should	ted				<del></del>					1 🗆 Y	'es 2	. No 3 P	robably	4 🔀 Unknown
3ec	e law has b	Completed							-		24a. Was a autop				ings available of cause of
<u>e</u>	n: Th ficate or, pag		25. Was case referred to medical						00 PI	15 41 4	1□ Yes	2 <b>X</b> No		2 □ No	)
₹	/slcia s certi	o Be	examiner?  1 Yes 2 No	Hospital:	Inpatient 2	TER/Outnatie	nt 3 🗆 DO/	A Othe	or.		Check only or		6 ☑Other (Spe	oify. <b>Hog</b> r	
0	Attending Physician: The lay r death. ector: After this certificate has by the funeral director, page 2		27. Manner of Death	28a. Date		28b. Time		Bc. Injun			d. Describe h			(CITY/L105)	rice
Sio	endin sath. or Af	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	ation	, 2 49 . 5417	,,	М		Yes 2 □ No	0					
Division or Vital Records, P.	fter de Direct	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ZOE, Flact	e of injury - At l ling, etc. (Spec	home, farm, st cify)	treet, factory,	, office		28	Location (S City or Tow		nd Number or R e)	ural Route	Number,
	To the Hospital or Attern within 24 hours after death To the Funeral Director completely filled in by the	Medical C		g Physician: To the Examiner: On the b											use(s)
	Fo the within:	Mec	29b. Signature and title of certifier		mer stateu.		29c.	. License	e number		- :	29d. Da	ate signed (Mon	th, Day, Ye	ear)
	0)		Cynthin 5	mo	llea	mi	HO	058	032		D	ece	mber 9,	2006	
•	19		30. Name and address of person	who completed cau	se of death (Ite	em 23a) (Type	, Print)				-				
1			Cynthia M. Will:	lams, D.O	., 6001	Munca	ster M	1 <b>i</b> 11	Road,	, Roc	kville	, M.	aryland	2085	5
	Sta Registi		31. Date filed (Month, Day, Year)	2006	Registrar's Sign	A CA	all I								

					artment of Health and M	•		0000
			1 - State Registrar		rtificate of Death	Reg. N	2000	39582
9		87 g	1 Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici /Medi		MARIANNE SC	DULES SHAV	7		10, 2006	6:15A M
100	Examir		4a. Facility Name (If not institution, give street a	nd number)	4b. City, Town, or Location of Death	4	c. County of Death	
			Wilson Health Care (		Gaithersburg  If Under 1 Year   If Under 24 Hrs.		Montgomery	
	Funeral Director		5. Sociaf Security Number 6. Sex	7. Age (In yrs. last birthday) 83 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	r) 9. Birthplac	e (State or Foreign
- 2			314-20-3674 Usual Residence of Decedent	03		Sept. 17,	1923 India	ma
	arylan	Ļ	10a. State 10b. County	10c. City, Town or Lo	ocation		10d	finside City Limits
	Be-f	Director	Maryland Montgomery	Gaithersb			(110)	1 XYes 2 No
	a or 2		10e. Street and Number		10f. Zip Code		itizen of What Country	?
	ns 23	Funerai	419 Russell Avenue	s Decedent Ever in U.S. 13.	20877 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto		ted States 14. Race - American	Indian,
9	or ite	Fur		Yes 2 XNo		Rican, etc.)	Black, White, etc	
21215-0036	72 hours atter death with the Maryland "natural", or items 23a or 28e-f show citical Examinat That be nutified at	d by	3 Wildowed 4 Divorced Yea	ar or Dates:	21		Specify: Whit	
15-	1 within 72 ho plene. r than "natur rre Medical	Completed	15. Decedent's Education (Specify only highest grade comp	leted) (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)	ng 16b.	Kind of Business/Indus	try
212	l within liene.	dmo	Elementary/Secondary (0-12) Col	lege (1-4or 5+)	emaker	O	wn Home	
	be tiled tal Hygid d other event, II	Bec	17. Father's Name (First, Middle, Last)	7		(First, Middle, Maide		
ylaı	D 2 2 0	To	George W. Soules		Edith S	trecker		
Maryland	d 2 shoulth and Mark		19a. Informant's Name/Relationship (Type, Printer)		ng Address (Street and Number or Rura			
	1 an Healt em 2 ther		Harmon Lee Shaw/Hus	20b. Place of Dispo	ussell Avenue, Gai		, Mary Land Location - City or Town	20877
Baltimore,	0 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova	from State Highland	Lawn Decen	nber		
altir	in in it		4 Donation 5 Other (Specify) Fint  21. Signature of Funeral Service Litensee	22	2. Name and Address of Facility Rot	2006 Ter Dert A. Pu	re Haute, mphrev Fund	Indiana eral Home/
ä	permit. Depart Import any inj		23a. Part 1. Enter the disease, or complications	M00803 R	ockville, Inc. 300	West Mon	tgomery Ave	enue
	<b>€</b> ≥		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do not ent	er the mode of dying, such as cardiac of	or respiratory arrest,	1111	IGLASI DOTAGELL
	Physician		fmmediate Cause (Final disease or condition	cute con	brovasce	lasac	cident ?	net and Death
1	/Medical Examiner		resulting in death)	due to (or as a consequence of):				
		e	Sequentially list conditions,	Due to (or as a consequence of):				
the	uted d ansit	Examin	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. ,				
ó	be executed icien and burial-translt			due to (or as a consequence of):				
3760,	9 × 9	ical	d.					
89 x	The law requires that the death certitica tte has been signed by the attending phoage 2 should be delached for use as the	Physician/Medi	IF FEMALE:					
Вох	attend for us	cian	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Da	ıy Year
o.	at the de by the a	ysic		Unknown	Other (specify)			
ď.	es that igned b be deta	by P	Part fl. Other significant conditions contribution	ng to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the	ause of death?
ecords,	w require been sig should b	edt	Myellenser	u renalin	enficiency	1 🗆 Yes	2 ∐No 3 ☐ Probabl	ly 4 □Unknown
ecc	e law re hes be je 2 sho	Completed	Fistary of Dulm	maryembol	uneand	24a. Was an autopsy	24b. Were autopsy	findings available letion of cause of
<u>=</u>		Con	mornhophlele	Tie i + nenu	& I Chronisdesses	performed? 1 ☐ Yes 2 ☑ N	death?	
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?			Check only one)		
of	Phys	. To	1 ☐ Yes 2 ☑ No Hospital  27. Manner of Death 28a	1 ☐ Inpatient 2 ☐ ER/Outpatier  Date of Injury 28b. Time o		me 5 Residence 28d. Describe how in		
O	th. : After funer	tion	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year) Injury	f 28c. Injury at Work?  M 1 Yes 2 No	200. 00001100 11011 111	a.y cocarroa	
Division	or Attending after death. Director: After in by the fune	ifica	2 Cuiside 6 Could not be	Place of frigury - At home, farm, str	reet, factory, office		and Number or Rural R	oute Number,
ā	tal or Al	Certification:	4   Nothicide	building, etc. (Specify)		City or Town, Sta	(0)	
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edicai	(Check only 2 Medical Examiner: Or	To the best of my knowledge, death the basis of examination and/or in	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause( ed at the time, date a	s) and manner as state	d. e cause(s)
	To the within 2 To the Complet	Med	one) an  29b. Signature and title of certifier	d manner stated.	29c. License number		ate signed (Month, Da	
	To Too		VAR heat by	2-26-6				
,	: 1)		30. Name and address of person who complete	d cause of death (Item 23) (Type.	Print) 201 RUSSE	44 4-11	11/18	1000
	10		IN PURSET BIRSCH	13 ACH MA.	GA ITHERS	BURGI	emberl NULE NUS 200	877
7	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature		,		
1	Regist	ar	DEC 1 2 2006	Ellenne 18 Ba	2.00			

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar	State of Marylan			of Health an	d Mental Hy	giene	06 39583	
	Physicia		Decedent's Name (First, Middle, Last)	SAIA			**************************************	2. Date of Do	eath Day	Year (SAM	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, To	wn, or Location of D	_	4c. County		
	Funeral Director		5. Social Security Number 6. Sec	/ ( - /	last birthday) Yrs.	If Under 1 \ Months D	ear If Under 24		rth ay. Year) - 1937	9. Birthplace (State or Foreign Country) Ohio	,
	aryland show dat		Usuel Residence of Decedent  10a. State 10b. County		y, Town or Lo					10d. Inside City Limits 1 ☑X es 2 ☐ No	
	the Ma 28a-f	Director	MD n/a	Be	altimo	ore	ode		10g. Citizen of		
	3a or	io le	3703 E. Pratt S	Street		212			USA	,	
920	72 hours after death with the Maryland neturel; or Items 23a or 28a-f ehow digal Exame net must be motified at	by Funeral	11. Marital Status 1 ☐ Never Married 21 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Deceden f Yes, specify	Cuban, Mexican, P	? (Specify Yes or N uerto Rican, etc.)	o- 14. Rad Bla	ce - American Indian, ack, White, etc. fy: White	
21215-0036	L L	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th		(Give	dent's Usual C kind of work of DO NOT use in nemake	done during most of retired)	working		Business/Industry  vn home	
land 2	be filed ital Hygi d other event, I	To Be Co	17. Father's Name (First, Middle, Last) Paul Shepherd					Name (First, Middle		me)	
Maryland	2 Pa = 2		19a. Informant's Name/Relationship (Ty Vittorio Saia	<sub>рв. Print)</sub> husband	1			or Rural Route Numb . Baltin	-	n, State, Zip Code) MD 21224	M
Baltimore,	000		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)		lace of Dispo	sition (Name natory or othe Of E	of r place)	Date /1 4 / 0 6	20c. Location	- City or Town, State	
Balti	permit. Pag Department Important: I eny inlury o once.		21. Signature of Funeral Service Licens  Maria H.	Jennino	22	Name and A	Address of Facility  Conklin	Joseph I g St. Ba	N. Zanr altimor	nino Jr. FH ce, MD 21224	Ī
	Physician		23a. Part1. Enter the disease, or comparished, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused the death ne cause on each line.	n. Do not ent	er the mode o	f dying, such as cal	rdiac or respiratory	arrest,	Approximate Interval Between Onset and Death	
	/Medical Examiner			Due to (of as a consequence	uence of):						
	buted and ransit	Examiner	Sequentially list conditions, if any, leading to influed at cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque.	uenna of):						
8760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequent	uence of):						
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and a page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3 [	Ectopic preg Other (speci				ate of delivery onth Day Year	
<u>α</u>	quires that n signed bi uld be deta	۵	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cau	se given in Part I.		tobacco use con Yes 2 □ No	ntribute to the cause of death? 3 ☐ Probably 4 ⊟Unknown	
Records,	i: The law requi icate has been s ; page 2 should	Completed						24a. Wa auto pert 1 □ Yes	ormed?	Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No	
Vital	<b>E E</b> 5	Be	25. Was case referred to medical examiner?	dognital:			1	Death Check only	one)		
of	Jing After fune	atlon: To	1 Yes 2 No '  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		Other: 4 Nursi Injury at Work? 1 Yes 2 No		idence 6 Otl		
Division	o te	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, sti	eet, factory, o	ffice	28f. Location City or To	(Street and Num own, State)	ber or Rural Route Number,	
	To the Hospital or Att within 24 hours after of To the Funerel Direct completely filled in by	edical C		sician: To the best of my kno ner: On the basis of examina and manner stated.							
	To the within To the comp	Me	29b. Signature and title of certifier	054, Mil		29¢ L	icense number	34		ed (Month, Day, Year)	
	3		30. Name and address of person who c		n 23a) (Type,	- 0	UL P	LALE	BACTI	LLO 2004 NIRE MOZIZ	255
a de la companya de l	Sta Regista	ate rar	31. Date filed (Month, Day, Year)  DEC 1 2 200	32 Registrar's Signa	ature	2					

**Physician** /Medical Examiner

**Funeral** Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "neturel", or Items 23a or 28a-1 show eny injury or other treumatic event, the Modical Examinar must be notified at once.

Physician /Medical Examiner

To Be Completed by Funeral Director

			Cer	tifica	te of	Death			g. No2	006	39581
Decedent's Name (First, Middle, Las WILLIAM LOUIS								Date of Death Month DECEMBE	Day	Year 2006	3. Time of Death
Facility Name (If not institution, give	street and number)			4b. City	, Town, c	or Location of De				ounty of Death	10.4) A.
STELLA MARIS HO	SPICE			,	TIMO	NIUM				BALTIMO	RE
Social Security Number 6. Se	ex 7. Age	(In yrs. last bi	rthday)		Days	If Under 24 H	Irs. 8	Date of Birth	Year)	9. Birth	place (State or Foreign
14-01-7356	<b>X</b> M 2 □ F	93	Yrs.	WIOTHITS	Days	Tiours iv	8	3/13/19		MARY	ĽÁND
ual Residence of Decedent a. State 10b. County		10c. City, Tov	m or Loc	ation							10d. Inside City Limits
MD BALTIMO	⊋E.		WSO								1 □ Yes 2 No
e. Street and Number	···		711,001		ip Code			10	n Citiza	n of What Cou	ntry?
1303 CROWNFIELD	COLIDA			101. 21		239			g. Oniza	USA	nu y :
	12. Was Decedent B	ver in U.S.	13 V	Vas Dece			(Specif	v Yes or No-	14	. Race - Ameri	can Indian.
. Marital Status  1   Never Married 2   Married	Armed Forces?					Hispanic Origin? an, Mexican, Pu	uèrto Ric	can, etc.)		Black, White,	
3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	☐ Yes	2 No	Specify:			S	pecify:	WHITE
15. Decedent's Ed		16a			ual Occup			1	6b. Kind	of Business/In	dustry
(Specify only highest gra Elementary/Secondary (0-12)	de completed) Colfege (1-4or 5	+)	life. D	O NOT	use retire	during most of ad	working				
12TH GRADE			FIF	REMAI	N				BA	LTIMORE	CITY
. Father's Name (First, Middle, Last)								First, Middle, M	laiden Si	/mame)	
WILLIAM J. SCHE	UERMAN					E	LLA	DALY			
Pa. Informant's Name/Relationship (	Type, Print)	19	b. Mailin	g Addres	s (Street	t and Number or	Rural F	Route Number,	City or 1	own, State, Zip	Code)
NITA L. SCHEUERM	AN/WIFE	1	303	CRO	WNFI	ELD COU	RT	BALTIM	DRE,	MD 21	239
a. Method of Disposition  1 Burial 2 Cremation 3 C	Domoval from State	MOST F				(CP)	Dat	e 2	Oc. Loca	tion - City or To	own, State
4 Donayion 5 Other (Specify			ETER		CCMC	12,	/14/	2006 I	BALT:	IMORE,	MD
1. Signature of Funeral Service Licen	1500		22.	Name a	and Addre	ess of Facility	THE	JOHNS	ON F	UNERAL	HOME, P.A.
Skaller N.	Xkeyes_		8	521	LOCH	RAVEN	BLVD	TOWS	SON,	MD 21	286
3a. Part1. Enter the disease, or company shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do	not ente	er the mo	de of dyi	ng, such as care	diac or r	espiratory arre	st,		Approximate Interval Between
nmediate Cause (Final isease or condition	a DEMENTIA										Onset and Death
esulting in death)	u	a consequence	of):								•
accordingly, list conditions	b										
equentially list conditions, any, feading to immediate tuse. Lister Underlying	Due to (or as a	a consequence	of):								
ause (Disease or injury at initiated events	c										
isulting in death) Last	Due to (or as a	a consequence	of):								
	_ d										
FEMALE:									4	10.	
3b. Was decedent pregnant in the past 12 months?	23c. ff yes, outcome 1 ☐ Live birth	of pregnancy 2 □ Fetaf deat	h 3□	Ectopic ;	pregnanc	;y			23	d. Date of deliv Month	ery Dav Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 🗆	Other (s	specify) _					Wichter	Day . Sa.
			1- ab	4.4				02a Did tab			he cause of death?
art II. Other significant conditions o	onthouting to death of	it not resulting	in the un	idenying	cause gr	ven in Parti.	_			No 3 ☐ Prol	
							_	24a. Was ar autopsy	,	prior to co	opsy findings available
								perform	ed?	death? 1 ☐ Yes	
5. Was case referred to medicaf examiner?							Death (	Check only one			
1 ☐ Yes 2 😿 No	Hospital: 1 Inpatie			3 🗆 🗅	Ot Ot	her: 4 🗆 Nursin	g Home	5 Reside	nce 6	Other (Specia	W HOSPICE
	28a. Date of fnjur (Month, Da)	Year) 28b.	Time of Injury		28c. Inju Wo	iry af ork?	28	d. Describe ho	w injury	occurred	
7. Manner of Death							1				
7. Manner of Death 1	n			М	· · · · ·	]Yes 2□No					

DHMH 17 Rev 1/2001

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

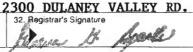
within 24 hours after death.

To the Funeral Director: After this certificate hes been sloned by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

31. Date filed (Month, Day, Year)

DR. TARIQ MAHMOOD

30. Name and address of person who compfeted cause of death (Item 23a) (Type, Print)



TIMONIUM, MD 21093

Division or Vital Records, P.O. Box 68760,

Saltimore, Maryland 21215-0036

2 State

31. Date filed (Month, Day, Year) Registrar

(Check only one)

29b. Signature and title of certifier

2

29c. License number 054288

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

OCCOMBON 8 9 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramolnanin

and manner stated

Northwest medical center

39. Registrar's Signature 2006

Nikia A. Smith 06-09311 UNK UNK

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ Decedent's Name (First, Middle, Last 2. Date of Death Nikia A. Smith Month Day December 6, 2006 1825 hrs Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4201 Erdman Ave Baltimore If Under 1 Year | If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8 Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreian March 5, 1976 214-88-6082 30 Country) Mary land Director 1 M 2 X F Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b. County Baltimore 1 **X** Yes 2 No 'natural', or items 23a or 28a-f show Examiner must be notified at once, Maryland permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at non-Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3315 McElderry Street United States 21205 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14 Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 Yes Black If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed 4 Divorced ð 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Domestic Housekeeping Baltimore, MD 21215-0036 1B.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julius Edward Jones Charlette A. Smith 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ Charlette A. Smith - Mother 3315 McElderry Street Baltimore, Maryland 21205 Dec. Date 15 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Baltimore, Maryland 1 Burial 2 Cremation 3 Removal from State Western Cemetery 2006 4 Donation 5 Other Specify: 22 Name and Address of Facility
Calvin L. Williams Funeral Service. P.A.
Pic. Box 11651 Baltimore, Maryland 21229 21. Signature of Funeral Service Lic. nsee alvin 2. 4 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Immediate Cause (Final disease Heroin and cocaine intoxication Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit Physician/Medical ending physician a use as the burial -X UNPENDED AMENDED #23a,27,8a-f, 1/5/07 TT P.O. Box 68760, IF FEMALE: 23c If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown page 2 should be detached for Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed' death? 1 🗸 Yes ✓ Yes 2 No To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical æ Other<sub>4</sub> Hospital: 1 Inpatient 2 examiner? ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene 1 🗸 Yes 2 No 28a Date of Injury (Month, Day, Year 2Bc. Injury at Work? 28d Describe how injury occurred 28b. Time of Injury 27. Manner of Death <u>0</u> To the Hosping - ...
within 24 hours after death
To the Funeral Director: A Natural Yes 2 No Pending Fnd 12/8/2006 Fnd 6:00 pm unknown Certificat Accident Investigation 28f Location (Street and Number or Rural Route Number, City or Town, State) 4201 Erdman Avenue Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be determined (Specify) found in car 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. December 7, 2006 Ollek PM 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Patricia Aronica-Pollak MD. 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar

State of Maryland / Department of Health and Mental Hygiene 115

			State of Maryland / Department  Certificate		E 0 0 0	39587
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	/Medic Examin		4a Facility Name (If not institution, give street end number)	4b. City, Town, or Lo	cetion of Deeth 4c. County of Death	
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1	Year If Under 24 Hrs.  Days Hours Min.	8. Date of Birth 9. Birth (Month, Day, Year)	place (State or Foreign intry)
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	and **	-	Usual Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
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_	Within To the	Me	29b/Signature and title of certifier 29c.	License number	29d. Date signed (Month	
			Karles Antonol.	0060560	DECEMBER	7,2006
	17 /		30. Name end address of person who completed cause of death (Item 23a) (Type, Print)	, A) M	100 0	
	4		30. Name end address of person who completed cause of death (Item 23a) (Type, Print)  PHY ICAT KHETISKIAL 201, BACK RIVER N.	ECK KD. 7	107, BALTIMORE,	MD
	Sta	ate	31. Date filed (Nonth, Day, Year)  OF C 1 1 2006  37 Registrer's Signature			

Registrar

2006

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Ce	rtificate of L		, 0	g. No.?	6 39589
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	/Medic Examin	11.00	4a. Facility Name (If not institution, give street a Bon Secours Hospital		4b. City, Town, or Baltimor			4c. County of E	Death
2	Funeral Director		5. Social Security Number 6. Sex 1 M 2[	7. Age (In yrs. last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 1, 196	Year)	Birthplace (State or Foreign Country)
	nyland how lat		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the Ma 28a-f s	Director	MD Charles  10e. Street and Number	Pomfret	10f. Zip Code		10	ng. Citizen of Wha	
	3a or		8698 King George Ct		2067	E		USA	t Gounty :
	ems 2	Funeral	11. Marital Status 12. Wa	s Decedent Ever in U.S. 13. ned Forces?	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - A	American Indian, White, etc.
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	X.X. If Y	Yes 2 T No es, Give ir or Dates:	1 ☐ Yes 2 ☐ No	Specify:		Specify. h	
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and	l be file ntal Hy ed oth event	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		laiden Surname)	
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	and 2		Toni Johnson Sist	er 31	6 Jerlyn Ave	, Linthicur	n, MD 2109	90	
ore	Pages 1 and the nent of He nent of He nent of He nent of the nent nerth or oth		20a. Method of Disposition 1 ☐ Burial 2 <b>EX</b> Cremation 3 ☐ Remova	20b. Place of Disp cemetery, cre	osition (Name of ematory or other plac	e)	Date 2	20c. Location - Cit	y or Town, State
Baltimore,	7 H e 8		4 □ Donation 5 □ Other (Specify)  21. Signal of Funeral Service License	Bayview Cr	ematory 22. Name and Addres	12-12	-06   [	Baltimore,	MD
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	. 4		30. Name and address of person who complete		MA MA	21 223	AITIMO	VRST.	06 Baltimore
₹.	Sta Regist		31. Date filed (Month, Day, Year) DEC 1 2 2006	32. Registrar's Signature					

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ב ק	othe ont,	BeC	17. Father's Name (First, Middle, L				1			r's Name (Fi	irst, Middle.	Maiden S	umame)		
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Maryland	th and Mer 7 is marke treumatic		19a. Informant's Name/Relationshi										Town, State, Z LAND 21		
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1	512		30. Name and address of person	who completed cause of 4940 EA	death (Item	23a) (Type	Print)		18015	1000-0	F	NOV	nber 9 LANS	2122	, y
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ORIGINAL

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			1. Decedent's Name (First, Middle, Last)							2. Date of Deat Month	h Day H	Year	3. Time of Death
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			Northwest Hospita  5. Social Security Number 6. Sex	7. Age (In yrs.	last hirthday)	If Under		dallst		8. Date of Birth		Balti	
, de-	Funeral Director			M 2X1F 8		Months	Days	Hours	Min.	(Month, Day,	Year) 1919	) Co	hplace (State or Foreign nuntry) aryland
, la		1	Usual Residence of Decedent							107. 10	,	7 110	
	how		10a. State 10b. County	10c. Cit	, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	e Ma Sa-1-e	cto	MD Baltimo	ore	Ba	ltimo							
	or 2	Funeral Director	10e. Street and Number			10f. Zip	Code	04.00	.=	1	0g. Citizen (	_	,
	s 23s	rai	1722 Hall Avenue	2. Was Decedent Ever in U.	C 12 1	Nas Doco	dent of His	2122		dy Ves or No-	Unite		ates orican Indian,
	ter de	'n	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?	J. 13.	f Yes, spe	cify Cubar	n, Mexican,	Puerto R	ify Yes or No- lican, etc.)	E	llack, Whit	e, etc.
99	urs af	þ	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2[XNo	Specify:			Spe	cityWhi	te
21215-0036	within 72 hours after deeth with the Maryland ene. Then "neturel", or items 23a or 28a-1 ehow he Medical Examiner must be notified a	Completed	15. Decedent's Educ		16a. Dece			ition uring most o	of workin	a	16b. Kind of	Business	Industry
2	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT L	se retired,						
7	ygier ygier her th		10			Home	make:		's Nome	(First, Middle, I	Anidon Sur		Home
and and	be fi	Be	17. Father's Name (First, Middle, Last)  John Weedon							Theres			
Ž	d Meu d Meu mark matic	ဥ	19a. Informant's Name/Relationship (Typ	oe Print)	19b. Mailir	a Addres	s (Street a			Route Number			Zip Code)
Maryland	od 2 s ith an 27 is r trau		Patsy Weedon			-				ay, MD			
ē,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or items 23a or 28a-1 show amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at anonge.		20a. Method of Disposition	20b. F	lace of Dispo	sition (Na	me of	9)	Da	ate	20c. Locatio	n - City or	Town, State
Baltimore,	Page nt: # rry or		1 Burial 2 Cremation 3 And 4 Donation 5 Other (Specify)	emoval from State Lal	emetery, crer KEVIEW			- 1	L2 <b>-</b> 9-	-2006	Sykes	sville	e, MD
alti	Depermit Depertmit Importe any inju		2 Signature of Funeral Serv > Lizense	is The	22	. Name a	nd Addres	s of Facility	Aml	prose Fi	uneral	L Home	e,Inc.
<u> </u>	82 = 3		Momelle .	ellenous		1328	Sulp	hur SI	oring	g Rd., A	Arbutu	ıs, M	) 21227
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the deat e cause on each line.	. Do not ent	er the mo	de of dying	g, such as c	ardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	SE	PTIC	SMO	Y CK						0.1001 4.10 004.11
	/Medical Examiner		resulting in death)	Due to (or as a conseq			$\wedge$						
		<u></u>	Sequentially list conditions. but any, leading to immediate	. VERF	ORA T	TED	15	OWE	<u>L</u>				
/	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	01	AE U	no ni	110						
Ć.	be executed sicien and burial-transit	Exa	that initiated events c resulting in death) Last	Due to (or as a conseq			- Printer						
8760,	cate be ex physicien the buria	dical											
9		Med	IF FEMALE:										
Вох	eath certific attending p	an/	23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3	Ectopic p						Date of de Month	livery Day Year
<u>o</u> .	The law requires that the death certific Ne hes been signed by the attending p page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 X No 9 □ Unknowh	4☐Pregnant at time of d 9☐Unknown	eath 5L	Other (s	pecify)	· · · · · · ·					•
<u>α</u>	that the		Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did tol	oacco use c	ontribute to	o the cause of death?
ds,	sign ed b	d by	DEMENTIA!							1 🗆 Y	s 2 No	3 □ P	robably 4 Kunknown
Ö	w requir been si should	ete								24a. Was a	n 24	b. Were a	utopsy findings available
Be	The lavelete hes	ompieted								autops perform	ned?	prior to death? 1 \( \text{Yes}	utopsy findings available completion of cause of 2 No
ta		C	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes : (Check only on	/	1 1 1 1 1 1 1 1	2/4/10
<u> </u>	Z 2	To B	examiner? 1 ☐ Yes 2 No	lospital: 1 Inpatient 2	ER/Outpatier	nt 3 D	OA Othe	er: 4 ☐ Nur	sing Hor	ne 5 ☐ Reside	ence 6 🗆	Other (Spe	ocify)
0			27. Manner of Death 1 ØNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	ıt	28c. Injury Work	at c?	2	8d. Describe h	ow injury oc	curred	
Sio	ttendii death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be			М		Yes 2□N		0/ 1 /0			10 11
Division of Vital Records,	after death after death Director;	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specil	ome, farm, st y)	reet, facto	ry, office		2	City or Town		imber or H	ural Route Number,
	pital Durs a Durs a Meral (		29a. Certifier 1X Certifying Phys	sician: To the best of my kno	wiedne, deat	h occurre	d at the tim	ne date and	f place, a	nd due to the c	ause(s) and	manner a	s stated.
	Hospital     24 hours     Funeral letely filled	Medical		ner: On the basis of examina and manner stated.									
	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	Me	29b. Signature and title of certifier	×20 01-			c. License			- 1	•	•	th, Day Year)
	45		> opograva P	m-ella				141	-		se wh	hev	06", 2006.
	13		30. Name and address of person who co	empleted cause of death (Iter	n 23a) (Type,	Print)	TO GI	MDER	P	MEHT	A		
				ISPITAL CE		RA	NOB	UST	· OW	M MI	> 2	1133	
	Sta Regist		31. Date filed (Month, Day, Year)	32. legistrar's Signa	A CA	sile							

				State of Maryla				•	•	
		•	1 - For State Registrar	1		rtificate of D		Reg. No	71116	39592
	Dhuciai	an	1. Decedent's Nam (First, Middle, Las	V) V)			2	Date of Death Month / Da	y / Year	3. Time of Death
-	Physici /Medic	al	Lewist. W	Inchies				12/09	12006	9,00PM
16	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo	ocation of Death	MD fo	County of Death	General
40	Funeral		5. Social Security Number 6. So	ex 7. Age (In yr	rs. last birthday)		f Under 24 Hrs.	Date of Birth	9. Birth	hplace (State of oreign
No.	Director		227–20–7840	ØM 2□F 8	32 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Year) 07/16/1924	1	VA
	and		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Le	ocation				10d. Inside City Limits
	Maryl	ţor	MD Prince G	eorge's	Fort Wa	shington				1 Yes 2 □ No
	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or lieme 23a or 28a-f ahow avent, I'm Medical Exatt, er must be notified at	ai Director	10e. Street and Number 602 Kawa Court			10f. Zip Code 20744		1	tizen of What Co	untry?
	eme er me	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Specif Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Amer Black, White	
36	rs afte	by Fu	1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 <b>7</b> € Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2120 No	Specify:		Specify: Am	frican erican
8	2 hou atura cal E	ted t	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occupation	on	16b. K	(ind of Business/l	
215	thin 7.	Completed	(Specify only highest gra	de completed) Coltege (1-4or 5+)		kind of work done dur DO NOT use retired)			П	and with an or
121	filed with Hygiene ither thai		12 17. Father's Name (First, Middle, Last)		נע	lesel Mecha		First Middle Meides		cking
Maryland 21215-0036		To Be	Donley Winckle	r			Annie I	Farrar		
	Ith as 27 is		19a. Informant's Name/Relationship (7 Essie Winckler /	**		ng Address (Street and 2 Kawa Cour				
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cre aceland	osition (Name of matory or other place) Memorial	12/16,		ocation - City or nilworth	
Balti	permit. Pages Department of importent: If it any injury or o		21. Signature of Funeral Service Licen	llarshall	Park 2	Name and Address Charles L. 1501 East	of Facility Stevens Fort Aver	Funeral H	Home Inc imore, M	D 21230
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the de	eath. Do not en					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	A	eime					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):					
Ale T		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a cons	equence of):					
8760,	~ × •	lical		, d						
x 68	death certificate I attending physi	Physician/Medi	IF FEMALE:	23c. If yes, outcome of pred	manov				00.1.0	
Box	atten atten	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fe	etal death 3[	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of deli Month	Day Year
P.O.	that the de led by the a detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		,,,,				
of Vital Records, F	S 500	by	Part II. Dther significant conditions of	ontributing to death but not r	resulting in the u	inderlying cause given	in Part I.		use contribute to	the cause of death?
000	aw require is been sig 2 should t	Completed						24a. Was an	24b. Were au	topsy findings available
Ä	The lav	Com						autopsy performed? 1 Yes 2 No	death?	completion of cause of 2 ☐ No
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			6. Place of Death (	Check only one)		
of	d is	. To	1 Yes 2 No	1 Inpatient 2	ER/Outpatie		4 Nursing nome	5 Residence		cify)
OU	th. After	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	) Injury	Work?	s 2 No		,, 00001100	
Division	Attendi	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, st	reet, factory, office	28	Location (Street ar City or Town, State		ural Route Number,
Ö	itel or irs after rel Dii			building, oto. (ope	,,			ony or rown, oran	·/	
	To the Hospital or Attending Physipin 24 hours after death. To the Funeral Director: After the cumpletely filled in by the funeral	Medical	29a. Certifier 1 Sertifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my k niner: On the basis of exami and manner stated.	knowledge, deal ination and/or in	th occurred at the time, evestigation, in my opin	date and place, and lion, death occurred	due to the cause(s at the time, date an	) and manner as d place, and due	stated. to the cause(s)
ge .0	To the within 2 To the	Me	29b. Signature and title of certifier			29c. License n	number	29d. Da	ate signed (Month	h, Day, Year)
)	7		1 Weth 6-10	une by		D35	206	D	combe	10, Jul
	6		30. Name and address of person who	Markett Boront Chil	tem 23a) (Type	Print) Vingeton R	and Fut	WASH	ma ma	y (m)
	Sta		31. Date filed (Month, Day, Year)	32. agistrar's Sig	gnature	9-00-	1	/- (4)	day and	
	Registi	rar	DEC 1 2 2	006 January	B. A.	ACCEPTED TO				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Frederick M. Walsh 8:00 A /Medical Dec. 10 2006 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2188 Woodbine Road Woodbine Carroll 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Country) 1928 Rhode Island **Funeral** Months Days 1 MM 2□F 78 14, Director 002-12-3898 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director Carroll Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2188 Woodbine Road 21797 **USA** 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify. Specify. 3 X Widowed 4 ☐ Divorced Year or Dates: WW TT white white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Senior Chief Petty Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Walsh 2 Ruth Harrington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Walsh - Son 2188 Woodbine Road Woodbine, MD 21797 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 4 □ Donation 5 □ Other (Specify) Dec. 12, 06 Baltimore, MD 21. Signature of Funeral Service Licens Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Medicorprie Physician months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No autopsy perform 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Piccontric 11, Zact 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kacree 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink 06-09113 State of Maryland / Department of Health and Mental Hygiene Ronny Williams 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Month Day November 30, 2006 1528 hrs Williams Medical Examiner Ronny 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 3927 Woodridge Road 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) 5. Social Security Numbe 6. Sex **Funeral** Foreign Days Hours Director 43 SC 05 08 Country) 214-40-9189 1 XM 2 63 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits any 10a State 1 X Yes 2 No Baltimore 28a-f show NA MD death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number items 23a or 28a-ist be notified at U.S.A. 21229 3927 Woodridge Road 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No. Funeral 2. Was Decedent Ever in U.S. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes 2 **X** No ori If Yes, Give Year 1 Yes 2 X No specify: Specify Black after Widowed Divorced "natural" ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) marked other than Various Jobs MD 21215-0036 Laborer 8th grade permit Pages | and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other th 18 Mother's Name (First, Missle Maiden Surname) 17 Father's Name (First, Middle, Last) Annie Mae Thomas M. Williams Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 21221 1448 Maple Ave, Essex, Md Elaine Hudgins-Sister Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition Baltimore, crematory or other place) Nurial 2 Cremation 3 Removal from State 12/8/06 Randallstown, Memorial Park King Other Specify Donation 5 22. Name and Address of Facility 21 Signature Funeral Service Licenses March F/H West 4300 wabash Ave, Baltimore, 21215 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part Enter the disease, or complicat **Physician** Between Onset and failure. List only one cause on each M-dical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical x AMENDED ITEM#18, perFH, G864, 2/7/07.WS UNPENDED g physician a Division of Vital Records, P.O. Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ð 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an been prior to completion of cause of autopsy After this certificate has performed? death? No ✔ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Be examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 Nursina Home 5 Residence 6 🗸 Other Scene ဂ 1 V Yes No 28d Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 🗸 Natural 1 Yes 2 No 5 Pending after death the 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 計 and manner stated ڡ 29c. License number 29d Date signed (Month, Day. Year) Signature and title of certifier December 1, 2006 OCME 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Southall, MD

DHMH 17 Rev 1/2001 OCME 2006

State

Registra

31. Date filed (Month, Day, Year)

Registrar's Signat

2006

		•	For State Registrar	State	e of Ma	ırylan				ealth a Death	and M	lental Hy	giene Reg. No2 0	06	39595
	.4		1. Decedent's Name (First, Mide	tie, Last)								2. Date of Dea		Year	3. Time of Death
	Physicia /Medic	al .	WILLIS	Willia		•						11	26	2006	9.00 AM
	Examin	er	4a. Facility Name (If not instituti							Location of	of Death		4c. County	of Death	
			Future Care I  5. Social Security Number	rvington 6. Sex		(In vrs. i	last birthday)	1	Balti 1 Year	more If Under	24 Hrs.	8. Date of Birt	h	9. Birthp	lace (State or Foreign
9	Funeral Director		578-54-4642	1 X M 2□		66	Yrs.	Months	Days	Hours	Min.	(Month, Da	v. Year)	Cour	ington DC
	D.		Usual Residence of Decedent												
	arylar	_	10a. State 10b. Count	У		10c. City	y, Town or Lo							1	0d. Inside City Limits 11 Yes 2 No
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	with ti	Funeral Director	10e. Street and Number					10f. Zip	Code	0100	0		10g. Citizen of		nty?
	eath ne 23	erai	22 S. Athol Av		Decedent E	ver in U	S. 13.1	Was Dece	dent of Hi	2122		ecify Yes or No		USA ce · Americ	an Indian,
<b>'</b>	r Hen	E	1 Never Married 2 Ma	arned 1 🗆	ed Forces? Yes 2∭XN			If Yes, spe	cify Cuba	n, Mexican	, Puèrto	Rican, etc.)	Bla	ck, White,	
8	72 hours after death with the Maryland natural; or teme 23a or 28a-f show dreal Examiner must be notified at	by	3 ☐ Widowed 4 ☑ Divorce	d If Ye	s, Give			1 🗆 Yes	2 <b>X</b> №	Specify:			Specif	y: bla	ick
21215-0036	d within 72 hours after death with the Marylan Jene. I than "naturat, or Itema 23a or 28a-1 show The Madical Examinat must be nutified at	Completed	15. Decede (Specify only high	ent's Education	eted)		16a. Dece	kind of wo	rk done d	during mos	t of work	ing	16b. Kind of B	lusiness/In	dustry
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12	Hygie Hygie ther t		12 17. Father's Name (First, Middle	0			e1	_ectr	lc1ar		ar's Nam	a (First. Middle.	home i		ements
and	a a b	o Be	Jesse C. Wil									Blackwe		/	
Maryland	2 should be and Menta te marked aumatic ev	2	19a. Informant's Name/Relation	nship (Type, Prin	t)		19b. Mailir	ng Address	S (Street a				er, City or Town,	, State, Zip	Code)
	s 1 and 2 should t Health and Men item 27 is marks other traumatic		Warren Willia	ms/broth	er		9003	Lave	11e	Court	Che	evy Chas	se, MD 2	20815	
J.G			20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 Demousi	from State	20b. P	lace of Dispo	sition (Na.	me of	Į.		Date	20c. Location		own, State
Ë	Pages ment of ant: if it ury or o		4 Donation 5 NOther	(Specity) in	state					į					
Baltimore,	permit. Page Department of Important: if any injury or onca.		21. Signature of Funeral Service Ronald	e Wade	Pir	ector	s S	late tate altim	Anato	omy B	oard 2120		Baltim	ore S	Street
H	(A)	1	23a. Part1. Enter the disease, shock, or heart failure. Li	or complications st only one cause	that caused on each lin	the deatl	h. Do not ent								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	2	Adva	MC	e	lur	P	Caus	cer	/ E rue	tastase	2	Onset and Death
	/Medical Examiner		resulting in death)	Di	ue to (or as	a conseq	uence of):								
	LAdiffile		Sequentially list conditions,	b	ue to (or as	2 000000	uana of):								
	led Islt	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>√</b> "	ie to (or as i	a conseq	derice or).								
	be executed sicien and burial-transit	Examin	that initiated events resulting in death) Last	C	ue to (or as	a conseq	uence of):								
8760	death certificate be executed e attending physicien and nd for use as the burial-transit	cai													
9	tificat ig phy as the	ledicai													
Вох	eath certific attending pl for use as (	an/N	IF FEMALE: 23b. Was decedent pregnant		s, outcome Live birth			⊒Ectopic p	regnancy					ate of delive	Day Year
	e deatl	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Pregnant at Unknown	time of d	eath 5	Other (s	pecify)				1910	OHH	Day real
P.0	that the de led by the detached		Part II. Other significant condi	itions contribution	n to death bi	it not res	ulting in the u	ınderiving	causa dive	en in Part I		23e. Did to	obacco use con	tribute to th	he cause of death?
ds,	uires tha signed Id be del	d b	_		//	~	uning in the u	g	Jan 30 g				Yes 2 □ No	3 ☐ Prob	
Sor	w requ	ete	of acres di	dis o	1000	,						24a. Was	an 24h	Were auto	psy findings available
Vital Records,	The law requires that the sete has been signed by the page 2 should be detache	Completed	allan	MU3 U	aug							autop	psy prmed3/	prior to co death?	mpletion of cause of
tal		a	25. Was case referred to media	cal						26. Place	of Deat	1 ☐ Yes h (Check only o		1 🗆 Yes	2U NO
<u>&gt;</u>	Physician: this certificant	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	1 🗌 Inpatie	nt 2 🗆	ER/Outpatie	nt 3 D	OA Oth				dence 6 □Ott	her (Specif	(y)
Jo u	ding Ph h. After th funeral		27. Manner of Death  1 Natural 5 □ Pen		Date of Injur	y Year)	28b. Time o	of	28c. Injun Worl	y at k?		28d. Describe I	how injury occur	rred	
Si.		catic	2 Accident inve	stigation				М		Yes 2 🗆	No				
Division	ei or Attend s after death ii Director: ed in by the	Certification:		mined 288.	Place of Injubuilding, etc	ury - At he c. (Specif	ome, farm, st (y)	reet, factor	y, office			28f. Location (: City or Tox		ber or Rura	al Route Number,
	To the Hospitei or Attenwithin 24 hours after deating the Funeral Director: completely filled in by the	edical (		ying Physician: al Examiner: On and		examina									
	To th withir To th comp	Me	29b. Signature and title of certi	fier				29	c. Licens	e number	2	7	29d. Date signe	ed (Month,	Day, Year)
			A MIT Rud	MI	)				ソ	211		(	12/	7 10	4006
			30. Name and address of person A - A HM E	on who completed	cause of d	eath (Iter	n 23a) (Type,	Print)	aw	57	7—	Bull	imore	MI	5006
	Sta Regist	ate rar	31. Date filed (Month, Day, Ye	3 2006	3. Registr	ar's Signa	ture	uli)							

		1- For State of Marylan Registrar		rtment of H		ental Hygie Reg.	700	5 39596
		Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
Physic /Med		Iona Elizabeth Wallace			1	Month December	02 200	1.4
Exam		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County of E	
		Greater Laurel Health		Laure	<b>1</b>		Prince	Georges
Funera	1	5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye		Birthplace (State or Foreign Country)
Directo	r	213–18–3344 1 1 M 2 X 86	Yrs.			gust 15,		aryland
pu *	7	Usual Residence of Decedent  10a, State 10b, County 10c, Cit	y, Town or Lo	ration				10d. Inside City Limits
aryla eho	5		Laurel					1 ☐ Yes XXNo
Sa-f	Director		Dauter			1.0	0111	
with t		10e. Street and Number		10f. Zip Code			. Citizen of Wha	,
1215-0036 within 72 hours after death with the Maryland ene. then "natural", or Items 23s or 28s-f ehow he Mayles! Exemples Files the healifies at	Funeral	13316 Santa Anita Road	0 40 1	20708				tes of America
lten lten	in in	11. Marital Status  12. Was Decedent Ever in U. Armed Forces?  15. Nover Married 25. Named Forces 25.	5. 13. V	Yas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto F	Rican, etc.)		American Indian, Vhite, etc.
36 rs aft	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 █ No If Yes, Give 3 █ Widowed 4 ☐ Divorced Year or Dates:	1	☐ Yes 2 No	Specify:		Specify:	White
21215-0036 ad within 72 hours af giene. or then "natural; or the Medical Exert.	be	15. Decedent's Education	16a Deced	ent's Usual Occupa	ution	161	b. Kind of Busine	ass/Industry
15 in 72	Completed	(Specify only highest grade completed)	(Give	kind of work done d OO NOT use retired)	furing most of workir )	ng , in	b. Italia or basan	ood in dustry
The state	E O	Elementary/Secondary (0-12) College (1-4or 5+)  2		al Secret		1	Lega1	
Hyg Hyg	BeC	17. Father's Name (First, Middle, Last)		ar beeree	18. Mother's Name	(First, Middle, Mai	iden Surname)	
and be ental ked of cov	To B	Joseph Roman Yox			Minerva	Schaffer		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural; or Items 23a or 28a-f show eny injury or other traumatic event, the Madical Examinat must be notified at	-	19a Informant's Name/Relationship (Time Print)	19b. Mailin	g Address (Street a	and Number or Rura			te, Zip Code)
other trau		Rev. Dr. G. Bradford Wallace	12216	Canta An	fe- N1	4-230224		1 00700
Head the other	1 2	20a Method of Disposition 20b. P	lace of Dispos	sition (Name of	ita Road	Laurel,	c. Location - City	nd 20/08 ror Town, State
no ages	1 3	1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State	emetery, cren	natory or other place	<b>3</b> )			
altimore, mit. Pages 1 a partment of Hee portant: If Item y Injury or othe		21. Signature of Funeral Service Nicensee	10 CTE	Name and Addres	s of Facility I ord	DO DE	Itimore	, MD. 21228 l Directors,In
Demi		Josef O. Kollner (MOC)	1 0					aryland 21133
		23a. Ray 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.		er the mode of dying	g, such as cardiac or	respiratory arrest	,	Approximate Interval Between
Physician			E551	1/18 7	DEMANT	IA		Onset and Death
/Medica	-	disease or condition resulting in death)  a. Due to (or as a consequence)			Z. Will			-
Examine	1		•					
1	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)	uonce of).					
uted d	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.						
exec on an ial-tr	EX	resulting in death) Last Due to (or as a consequence of the control of the contro	uence of):					
18760, cate be executed physician and the burial-transit	dlcal	d.						
68 ifficat g phy as th	40							
I Records, P.O. Box 63 The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregna					23d. Date of	delivery
P.O. By that the death ed by the atterded for	<u>S</u>	in the past 12 months?  1		Ectopic pregnancy Other (specify)			Month	Day Year
by the tache	hys	9 Unknown 9U Unknown						
s that	by P	Part II. Other significant conditions contributing to death but not rest	ulting in the un	derlying cause give	n in Part I.	23e. Did tobac	co use contribut	e to the cause of death?
rds, quires in signa	9	Koriasis				1 🗀 Yes	2 No 3	Probably 4 Winknown
Cord w requir been si	ete					24a. Was an	24h Were	autopsy findings available
f Vital Recysician: The lavis certificate has	Completed					autopsy performed	prior deat	to completion of cause of h?
Vital F ician: Th certificate rector, pag	ပိ	25. Was case relevant to marked				1 ☐ Yes 2 ☑	No 1 🗆	Yes 2□ No
Vii sicia cent	00	25. Was case referred to medical examiner?  1   Yes   2 (DNo Hospital: 1   Inpatient 2	50.0	Othe	26. Place of Death			
Of Phys	5. To		ER/Outpatien 28b. Time of	28c. Injury	4 1 ursing Horr	ne 5 Residence 8d. Describe how		Specify)
dling Afte	i e	1 Natural 5 Pending (Month, Day Year)	Injury	Work	? (es 2 🗌 No		,,	
Vision of Vita Attending Physician: r death. sctor: After this certification the funeral director.	Ca	3 Suicide 6 Could not be 280 Blood of Injury. At he	me farm stre			8f Location (Stree	at and Number o	r Rural Route Number,
Division of Vital Records, to a translation of Vital Records, to Attending Physician: The law requires tatler death.  Director: After this certificate has been signed in by the funeral director, page 2 should be e	Certification:	4 Homicide determined building, etc. (Specify	<i>')</i>	ot, lactory, office		City or Town, S	State)	riasarriodio rambor,
Division  To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely illied in by the funer		29a. Certifier 1 Certifying Physician: To the best of my kno	wiedne death	occurred at the tim	e, date and place a	nd due to the caus	e(s) and manne	r as stated
24 h	Medical	(Check only 2 Medical Examiner: On the basis of examinal one)	tion and/or inv	estigation, in my op	inion, death occurre	d at the time, date	and place, and	due to the cause(s)
To the Hospita within 24 hours To the Funeral completely filled	₹ E	29b. Signature and title of certifier		29c. License	number	29d.	Date signed (M	onth, Day, Year)
- s - ō		hoop Kilkely un	)	20052	2075		2/11/0	
$\lambda$		30. Name and add as of person who completed cause of death (Item	23a) (Tuna	Print)	1 -	1.	11100	
Y\		NAR KURLETI 14101-1	BULADA	Warle Dr	. 223	Laure	1. m	) -20707
	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signa	ture	· W	,			
Regis		DEC 1 2 2006 Fielding &	Los	all s				

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ORIGINAL

		-	For State Registrar	State of	Marylan		artment <i>tificate</i>			d Mental H	ygien Reg. N	71115	39	597
Ĭ	Physicia		Decedent's Name (First, Middle     BETTY ELI	, Last) ZABETH WIN	NEBERG	ER				2. Date of Month	Death Death	Ř 7, Žůc		of Death
ÿ	/Medic Examin		4a. Facility Name (If not institution Saint Jose	, give street and numb	al Ce	nter	4b. City, 7	Town, or L	ocation of De	eath WSON	40	c. County of Deat		~e
i	Funeral Director	0,2	5. Social Security Number 213-30-3816	6. Sex 7.	. Age (In yrs.	last birthday) Yrs.	If Under		If Under 24 H Hours M	8. Date of (Month), 1/6/1	Day, Yeai	r) Co	nplace (State untry) YLAND	or Foreign
la.	P		Usual Residence of Decedent  10a. State 10b. County			y, Town or Lo	cation						10d. Inside	City Limits
	Maryl f sho	to	MD BALT	IMORE		PHOENI	X						1	es 2∭No
	r 28a	irec	10e. Street and Number				10f. Zip	Code			10g. C	itizen of What Co	untry?	
	th with site of the site of th	a D	12805 JARRETTS	VILLE PIKE	k.			211	31			USA		
-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral Director	11. Marital Status  1 X Never Married 2  Marr 3  Widowed 4  Divorced	12. Was Deced Armed Forci ied 1 ☐ Yes 2 If Yes, Give Year or Date	es? !⊡XNo		Was Deced If Yes, spec 1 ☐ Yes 2		panic Origin? , Mexican, Pu Specify:	(Specify Yes or lerto Rican, etc.)	No-	14. Race - Ame Black, White Specify:		
<u>ئ</u> م	72 hou	Completed	15. Deceden (Specify only higher	r's Education		16a. Dece	dent's Usua kind of wor	l Occupat k done du	ion ring most of	workina		Kind of Business/		
7	ithin ne.	mple	Elementary/Secondary (0-12)	College (1-4	4or 5+)					J	- 1	NUFACTUR		
7	iled w Hygiel <b>her ti</b> nt, th		8TH GRADE  17. Father's Name (First, Middle,	I act)		ASSE	MBLY			Name (First, Mide	_1			
and	d be f ental H red of	o Be	HOWARD WINNER	•						ULAH MER		,		
2	should nd Me mark imath	P	19a. Informant's Name/Relations			19b. Mailir	ng Address	(Street ar				or Town, State, 2	Zip Code)	
Z Z	alth a 27 Is 27 Is in trau		RUSSELL WINNEBE	RGER/BROTH	ER	1280	5 JAR	RETTS	SVILLE	PIKE F	HOEN.	IX, MD	21131	
Baitimore,	Pages 1 annount of Herant: If item		20a. Method of Disposition    Burial 2   Cremation 4   Donation 5   Other (S		tato i	Place of Dispo cemetery, crea KWOOD	matory or of	ther place,	12	Date /11/2006		LOCATION - City or		·
Balt	permit. Departr Importa any inju		21. Signature of Funeral Service	licensee Eleman					of Facility (			FUNERAL N, MD 2	HOME, 1286	P.A.
8/60,	Physician and buysician and street be executed by the principal francial fr	dical Examiner	23a. Part1. Enter the disease, on shock or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. RESI Due to (o ACU Due to (o	FIRAT r as a consec	ORY Figuence of): TRACE	AILU	RE			, and st,		Approxim Interval E Onset an	letween
.O. Box 6	ath certifi ittending I or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		nth 2 ☐ Feta ant at time of o	al death 3[	⊒Ectopic pr ⊒ Other (sp				-	23d. Date of del Month	ivery Day	Year
1	uires that the de n signed by the a ld be detached t	ρ	Part II. Other significant conditi		ath but not res	sulting in the u	nderlying a	ause giver	n in Part I.			use contribute to 2 XNo 3 □ Pi	the cause of the c	
Hecords,	Physician: The law require this certificate has been sis al director, page 2 should t	Completed	MYOCARDIAL IN	FARCTION						24a. W au po 1 Ye	utopsy erformed?	24b. Were au prior to death?	completion o	gs available f cause of
VItal	sician: The certificate I rector, pag	Be	25. Was case referred to medica examiner?	T .				1		Death (Check on	ly one)			
	Physical this contained and direction	2	1 ☐ Yes 2 X No			ER/Outpatie			4 🗀 IVUISIII	-		6 ☐Other (Spe	cify)	
5	ng fter ner	on:	27. Manner of Death 1 Natural 5 □ Pendir	ig .	n, Day Year)	28b. Time o	M 2	8c. Injury Work	at ? es 2 □ No	28d, Descri	oe now in	jury occurred		
Division or	To the Hospital or Attending Physician: within 24 hours after death.  Vo the Funeral Director: After this certification ompletely filled in by the funeral director,	Certification:	2 Accident investi 3 Suicide 6 Could 4 Homicide detern	not be 28e. Place of	of injury - At h g, etc. <i>(Sp</i> ec	lome, farm, st			es 2 110	28f. Locatio City or	n (Street Town, Sta	and Number or Ri ate)	ural Route N	umber,
	he Hospit in 24 hour he Funera pletely fille	Medical (		ng Physician: To the base Examiner: On the base and manner	sis of examin		rvestigation	, in my op	inion, death o		ne, date a	and place, and due	e to the caus	
	To the within To the compli	Σ	29b. Signature and title of certific	"   .(	$\supset$	W	290	. License	number			Date signed (Mont		")
	5	1	Michare	+ Liast	Sieun			D31	826		12	-7-0	5	
	10		30. Name and address of person	who completed cause	e of death (Ite									
			RICHARD III 31. Date filed (Month, Day, Year,	THICUM.	M.D. egistrar's Sign	76211 ature	OSL	ER D	RIVE	TOWSO	N. ME	RYLAND	2120	4
	Sta	ate	DEC 1 9		1	1 Con	ales							

		_	For	State of Marylan					Mental H	6	2006	39598
		7	- State Registrar			Certificat	e of L	<i>Jeal</i> II	2. Date of	Reg. No.		3. Time of Death
	Physicia		1. Decedent's Name (First, Middle, Last,	WOLFE	-				Month	Day	200°C	630PM
	/Medic		4a. Facility Name (If not institution, give			4b. City,	Town, or	Location of Dea			County of Dea	th
	Examin	er	MARLY 1-	TOS PITAL	_	13,	92T	MOR	$\epsilon$			N/A
	Funeral Director		5. Social Security Number 6. Sec. 17 - 98 - 0951	7. Age (In yrs.	last birth	Months	Days	If Under 24 Hr Hours Mir		71966		thplace (State or Foreign ountry) MD
	ō	þ	Usual Residence of Decedent	140-00	~							10d. Inside City Limits
	anylan ehow	-	10a. State 10b. County	106. Cit	•	or Location ALTIMORI	-					1 X Yes 2 □ No
	28a-1	Director	MD N/A				Code			10g. Citi	zen of What Co	ountry?
:	deeth with the Maryland ms 23a or 28a-f ehow r must be ricitified at	١	7301 PARK HEIGHTS	S AVENUE #303				21208				USA
	ms 2;	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	S.	13. Was Dece	dent of His	spanic Origin?	(Specify Yes or erto Rican, etc.)	No-	14. Race - Ame Black, Whi	
_	d within 72 hours after deeth with the Marylan place. I than "naturelt, or thems 23a or 28a-1 ehow the Madical Examinet must be inclifted at the Madical Examinet must be inclifted at	by Fu	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 MT No If Yes, Give Year or Dates:		1 🗆 Yes		Specify:			Specify:	WHITE
9500-c	2 hou		15. Decedent's Edu	ication		Decedent's Usu (Give kind of wo			rorkina	16b. K	nd of Business	/Industry
כוב	within 72 ene. than "n	Completed	(Specify only highest grad	College (1-4or 5+)	1	ALESMAN	se retired)	)	o.,,,,,g	RFT	AIL	
N	filed wii Hygien Sther th	Son			3/	AL LONAIN		18 Mother's N	ame (First, Mid			
and	B a a B	To Be	17. Father's Name (First, Middle, Last) BARRY		W	OLFE		EILE	·			COHEN
=	2 should and Miles mail		19a. Informant's Name/Relationship (T	ype, Print) FHER	19b.	Mailing Addres	s (Street a	ROVE DI	Rural Route Nu	nber, City o	r Town, State, IN BEACI	Zip Code) H, FL 33437
	1 and Heelth em 27 ther to		20a. Method of Disposition	20b. I	Place of	Disposition (Na	me of		Date		ocation - City or	
פֿ	M O		1 🕅 Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State		v, crematory or YESHURU			/11/2006	5 BA	LTIMOR	E, MD
	permit. Page Depertment of Important: if any injury of once.		21. Signature of Funeral Service Licens			1		s of Facility	SOL LEV	NSON	& BROS	., INC.
ñ —	88 = 8		Koleto/	0/	ر						SVILLE	, MD 21208 Approximate
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused the dea	th. Don				TIC		VEXNE	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consec	quence d	of):	, 20 1.	7310	13 (10	7	200.10	7/
	Examiner		Sequentially list conditions,	b		.0.						
	nsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	Ineuca c							
,	execu n and ial-tra	Exar	that initiated events resulting in death) Last	Due to (or as a consec	quence d	of):						
8760,	cate be executed bhysicien and the burial-transit	dical	(	d								
39 ×	ertifica ding pt		IF FEMALE:	23c. If yes, outcome of pregn	ancv						23d. Date of de	alivery
Вох	eath certific attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fet 4 Pregnant at time of	al death	3 ☐Ectopic   5 ☐ Other (s				_	Month	Day Year
P.O.	t the d by the ached	hysi	9 Unknown	9 Unknown								
S, F	The law requires that the death certificate be executed ate been signed by the attending physicien and been been been detached for use as the burial-transit	þ	Part II. Other significant conditions of	ontributing to death but not re-	sulting in	the underlying	cause give	en in Part I.		id tobacco ☐ Yes 2		to the cause of death?  Probably 4 Whitnown
Ö	requi	eted	(	1,100					24a. V	Vas an	24b. Were a	autopsy findings available
Bec	he law e hes l	Completed							_ a	utopsy enormed?	prior to death?	completion of cause of
ta	an: T tificat tor, pa	0	25. Was case referred to medical					26. Place of I	Death (Check of			
<u>&gt;</u>	nysici nis cer direc	To B	examiner? 1 ☐ Yes		]ER/Ou	tpatient 3 🗆 🛭		4   Nursin	g Home 5□F			ecify)
0	ing Ph Mter th uneral		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)		ime of njury M	28c. Injun Work	yat k? Yes 2∐No	28d. Descr	ibe how inju	ry occurred	
Division of Vital Records,	To the Hospital or Attending Physician: The i within 24 hours efter death. To the Funarel Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		nome, fa			103 2	28f. Location City or	on (Street a. Town, Stat	nd Number or F e)	Rural Route Number,
ō	oital or A urs efter irel Direc			ysician: To the best of my kn		death	d at the 4	ne date and -1	and due to	the causes	) and manner	as stated.
	24 hor Fund Fund etely fi	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exan	niner: On the basis of examin and manner stated.	ation an	d/or investigation	on, in my o	pinion, death o	ccurred at the ti	πe, date an	d place, and du	ue to the cause(s)
	To the Hospital within 24 hours of To the Funarel completely filled	Me	29b. Signature and title of certifier	7 6	1.1	2	9c. Licens	e number		29d. Da	ite signed (Mo	nth, Day, Year)
	/- /- 0		) Jasy	DSA			D	7243	4	DE	7 1	Zeste
	1		30. Name and address of person who			(Type, Print)	PAI	IL DI	Arc	344	more	50515 071
	· ·		31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	21	. /10		The c			3 0.0
	St	ate	DEC 1 2 20	106 Marie	d.	Gosser	7					

		-	For State Registrar	State	of Maryla	•	artment of F		nd Mental Hy	/giene Reg. No. (	06	39599
	A Y		Decedent's Name (First, Middle,	Last)					2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia /Medic		Tian Jiu Zha	ang					11	30	06	9:30 a M
	Examin	-	4a. Facility Name (If not institution,	-	ımber)		4b. City, Town, o	r Location of	Death	4c. C	ounty of Death	
		à	4409 Simmons		"		Temple If Under 1 Year		A Hre I a D	PG		lane (Ctata as Fassina
	Funeral			6. Sex 1X M 2 □ F	7. Age (In yrs	5. last birthday, 76 Yrs.	Months Days		4 Hrs. 8. Date of B (Month, D) 9/19/3	ay, Year)	Cour	• •
<b>\$</b>	Director		212-23-3970 Usual Residence of Decedent						9/19/	50	Chi	na
	yland		10a. State 10b. County		10c. C	ity, Town or L	ocation				1	0d. Inside City Limits
	Mar.	tor	MD PG		T	emple F	lills					1 XYes 2 No
	or 28	lred	10e. Street and Number			•	10f. Zip Code			10g. Citize	n of What Cour	ntry?
	238 (1)	aic	4409 Simmons L	ane			20748			Chin	<del></del>	
	tems	Funeral Director	11. Marital Status	Armed F		U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origi an, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	10-	<ul> <li>Race - Americ Black, White,</li> </ul>	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 □ Yes If Yes, G Year or I	2X No live		1 ☐ Yes 2 ☐XNo	Specify:		S	pecify: Chi	nese
9	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28e-f ehow the Marical Examinat rejuel the indiffed at	ed	15. Decedent		Dates.	16a. Dece	dent's Usual Occur	pation		16b. Kind	of Business/In	dustry
15	n na	Completed	(Specify only highes	t grade completed	) (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of d)	of working			
212	d with	E O	Elementary/Secondary (0-12) 6th	College	(1-401 3+)	Far	mer			Agri	culture	
פר	al Hyg	Bec	17. Father's Name (First, Middle, L	_ast)				18. Mother	's Name (First, Middi	e, Maiden Si	u <i>m</i> ame)	
/lai	Menta Menta arked	70 E	Jian Rui Zhan	g					Chen			
Baltimore, Maryland 21215-0036	2 sho and is m		19a. Informant's Name/Relationsh				,		or Rural Route Num			
3, 2	and ealth m 27 her tr		John Cheung/ne	pnew 	20h		osition (Name of	PKWY I	District H		S MD ZU	
Ore	ges 1 t of H Hite or ot		20a. Method of Disposition 1	3 Removal from	n State	cemetery, cre	matory or other pla					
ţ	t. Pa tmen tent:		4 Donation 5 Other (Sp		Ft	. Linco			2/11/06	Bren	twood,M	D
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importent: If Item 27 is marked other then "netural", or items 23a or 28e-f ehow any injury or other traumatic event, the Maralcal Example or interior williad at once.		21. Signature of Funeral Service t	9/10	eco	34	2. Name and Addres -01 Blade	nshuro	Road Bren	twood		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the de-	ath. Do not er	iter the mode of dyi	ng, such as ca	ardiac or respiratory	arrest,	,110 207	Approximate Intervat Between
	Physician		Immediate Cause (Final disease or condition		ASCVI	)						Onset and Death
	/Medical		resulting in death)	Due to	o (or as a conse	equence of):						
	Examiner		Sequentially list conditions.	b								
· ·	pa ii	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conse	equence of):						
	and Ftran	Examine	that initiated events resulting in death) Last	c. Due to	o (or as a conse	aquence of):						
8760,	ate be executed hysicien and the burial-transit				(0, 40 4 00.10.	<b>1</b>						
687	phys phys s the	dic		d					19.000			
	the death certificate be executed y the attending physicien and Iched for use as the buriat-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant		utcome of preg					23	d. Date of deliv	ery
Вох	death a atter	ciai	in the past 12 months?	4□Preg	birth 2□Fe gnant at time of		□Ectopic pregnanc □ Other (s <i>pecify</i> ) _	:y 			Month	Day Year
o.	the de by the tached	hys	9 ☐ Unknown	9□ Unk	nown							
۳,	The law requires that te has been signed b age 2 should be deta	by P	Part II. Other significant condition	ns contributing to	death but not re	esulting in the	underlying cause gi	ven in Part I.	23e. Dio	I tobacco use	e contribute to t	he cause of death?
ğ	v require been sig should b		CVA						1 [	]Yes 2□	No 3 ☐ Prot	bably 4X Unknown
006	law re as bea 2 sho	Completed							24a. Wa	s an	24b. Were auto	ppsy findings available impletion of cause of
æ	The I	mo							per 1 ☐ Yes	formed?	death? 1 ☐ Yes	
ita	certifice rector, p	Be	25. Was case referred to medical examiner?					26. Place	of Death (Check only	one)		
of Vital Records,	S 5	으	1X Yes 2 □ No			☐ ER/Outpatie	HIL SESTIDON		sing Home 5□ Re			(y)
		on:	27. Manner of Death 1X Natural 5 ☐ Pendin	9	e of Injury onth, Day Year)	28b. Time Injury	Wo		28d. Describe	how injury	occurred	
sio	ten leath tor:	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be	an of loison. At	home form		]Yes 2 □ N		(Street and	Number or Pur	al Route Number,
Division	o # in ⊡	Certification:	4 Homicide determ	ined 288. Plac	ding, etc. (Spe	city)	treet, factory, office			own, State)	Walliper or har	ar noble ivalliber,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier 1 Certifyin (Check only 27 Medical	g Physician: To the	he best of my k	nowledge, dea	th occurred at the t	ime, date and	d place, and due to the h occurred at the time	e cause(s) a	nd manner as s	stated.
	he H in 24 he F	edical	one) ZL	and ma	nner stated.				TOCCUITED ALL THE LITT			
	To T To I	Σ	29b. Signature and title of certifier	1	1		29c. Licen	se number	017		signed (Month,	
	1.		Melburt	Efol	will	nw.	NO	ve /	761	/	2/9/3	2006
	8		30. Name and address of person Dr. Albert E. R					ashing	ton,MD 20	744-55	43	
	Sta Regist	ate	31. Date filed (Month, Day, Year)		Pagistrar's Sig							
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State

Registrar

31. Date filed (Month, Day, Year)

NOV 28

32 Registrar's Signature

2006

Please Type or Print in Black Indelible Ink

Maryland / Department of Health and Mental Hygiene

Kristen Frost Ayn	,	State of Maryland / Department of Hea -For State Certificate of Dea			0000	2000
Physicia		Registrar  1. Decedent's Name (First, Middle, Last)		2. Date of Deat		ime of Death
Medical Examir	er	KRISTEN FROST AYMAR	T	Month November		2007 hrs
from .			Town, or Location of Dea xville	atn	4c. County of Death Washington	
Funeral			der 1 Year If Under 24H	_	rth(MM/DD/YYYY) 9 Birthplac	ce (State or
Director		215-48-1917   1 M 2XF   60 Yrs   Mont	ths Days Hours M	OCT. 8	Foreign WASHIN	NGTON, DC
any		Usual Residence of Decedent         10c. City, Town or Location           10a State         10b. County         10c. City, Town or Location			10d	Inside City Limits
* .			ROHRERSVILL	F		Yes 2 X No
arylan 8a-f sl at onc	~ _		p Code		Og Citizen of What Country?	<u> </u>
		20643 BENT WILLOW ROAD	21779		U.S.A.	•
th with	Funeral		lent of Hispanic Origin? ( cify Cuban, Mexican, Puer		14 Race - American Ir White, etc.	ndian, Black,
ter dea		1 Yes 2 X No	2 X No specify		Specify: WHI	ITE
ours afi attural	함	15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usua	al Occupation (Give kind o		16b. Kind of Business/Indust	try
6 n 72 ho an "ng ical Ex	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	orking life. DO NOT use re $\mathrm{PN}$	etired)	NURSING H	JOME .
5-0036 led within 7 Hygiene I other than the Medica	<u>E</u>	17. Father's Name (First, Middle, Last)		me (First, Middle, M		.iOrii
215 be filed ntal Hy rked o	Be C	ROBERT HENRY AYMAR		MAE HURW		
D 21; should b and Men 7 is mar					nber, City or Town, State, Zip (	· ·
, ME and 2 s calth a	1	20a Method of Disposition 20b Place of Disposition (Na	ame of cemetery	Date	ERSVILLE, MD  120c. Location - City or Town	21779 State
Baltimore, permit Pages I ar Department of Hee Important: If ite		1 Burial 2 X Cremation 3 Removal from State SMITHSBURG CR	EMATORY 11	/28/2006	SMITHSBURG,	´
altin mit Pa partmen portan	ł	4 Donation 5 Other Specify:	d Address of Facility		I D NATIONAL PIR	
Dept.	1	BAST F	UNERAL HOME	BOONSBO	RO, MARYLAND	21713
Physician /Medical		23a Part I Inter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line.	of dying, such as cardiac	or respiratory arre		proximate Interval etween Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  Multiple Injuries  Due to (or as a consequence of):				Death
		Sequentially list conditions, b				
	nine	If any, leading to immediate cause. Enter Underlying Cause Council or nor nor to a military of the council or nor nor to a military of the council or nor nor to a military of the council or nor nor nor nor nor nor nor nor nor				
ed	Examiner	events resulting in death) Last  Due to (or as a consequence of):				
execui an and al - tra	edical	UNPENDED AMENDED				
760, cate be physicii	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
c 6876 certificate ending phy use as the b	hysician/M	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 5 Other (Sp.		nancy	Month Day	Year
Box e death c the atten	hysi	1 Yes 2 No 9 V Unknown 9 Unknown	3019)			
P.O.	Dy P	Part II. Other significant conditions contributing to death but not resulting in the underlying	ig cause given in Part I		bbacco use contribute to the case 2 No 3 Probably	
ds, F				- 24a. Was a		
COFC	Completed			autop perfor	prior to comple rmed? death?	etion of cause of
Re		25 Was case referred to medical	26 Place of Death (Chec	1 Yes	2 No 1 Yes	2 No
Vital ysician his cen	o Be	examiner?	Othor		Residence 6 🗸 Other: Scer	ne
n of Vital Records, P.O. Box 68766 ing Physician: The law requires that the death certificate.  After this certificate has been signed by the attending phyfuneral director, page 2 should be detached for use as the b	-1	27 Manner of Death 28a Date of Injury 28b. Time of Injury	28c Injury at Work?		how injury occurred auto collision	
ivision or Attendi after death Director:	atio	2 Accident Investigation	1 Yes 2 V No			
Division of Vital Records, pital or Attending Physician: The law requinours after death eral Director: After this certificate has been sittled in by the funeral director, page 2 should tilled in by the funeral director, page 2 should be assumed to the funeral director, page 2 should be assumed the funeral director, page 2 should be assumed to the funeral director, page 2 should be assumed to the funeral director, page 2 should be assumed to the funeral director.	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / Highway	y, office building, etc.	or Town, S	Street and Number or Rural Ro State) r Garretts Mill, Knoxville, M	
spi hou ner		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the	ne time, date and place, a	1		
To the Hos within 24 h To the Fur	8	one) 2 Medical Examiner: On the basis of examination and/or investigation, in n and manner stated		d at the time, date		
	Σ	29b. Signature and title of certifier	9c License number		29d. Date signed (Month, D.	ay, Year)
	-	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		November 27, 2006	
SH-10		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street,	Baltimore, MD 2120	01		
Sta	ate	31 Date filed (Month Day, Year) 2006 32. Registrar's Signature				
Regist	έľ	NOV 29 2000 Blacen D. popular				

State of Maryland / Department of Health and Mental Hygien@ 1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Voar **Physician** Henry Bowman Nov 23 2006 2:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Genesis HealthCare -Talbot The Pines Easton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 29 192 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Min. Months Hours 1**X** M 2□ F Director 414-09-2975 1920 Tennessee Usual Residence of Deceden with the Maryland 10c. City, Town or Location 10d. fnside City Limits 10a State 10b. County "natural", or Items 23a or 28a-f show ofical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Caroline Maryde1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19010 Harmans Road 21649 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16b. Kind of Business/Industry filed within Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) photographer US Army 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 and Mental Silas Bowman Carrie Boyd Bowman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 19010 Harmans Road Marydel, Maryland 21649 Diane Haslup/ daughter Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If its any injury or of once. ŏ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery | 12/01/2006 ' 4 ☐ Donation 5 ☐ Other (Specify) Humboldt, Tenn 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA PO Box 160 Greensboro, Maryland 21639 age 7/ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardionuppath Hears **Physician** /Medical Due to (or as a consequence of)! Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequence of) Examiner The law requires that the death certificate be executed resourceso Hears that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician a hed for use as the burial-Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetaf dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetaf death in the past 12 months? Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has be 2 certificate 1 ☐ Yes To the Hospital or Attending Physician: : After this certification in the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Magner of Death 28b. Time of 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 60 RUW 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**OŘIGINAL** 

		For State Registrar	State of	f Marylan		irtment of F		and Mental Hy	/giene	4000	39603
Dhysisis		Decedent's Name (First, Middle, Last)						2. Date of D	Day	/ Year	3. Time of Death
Physicia /Medic		DONNA MARIE	BAKE					NOV.	23	2006	01:04 A M
Examine	er	4a. Facility Name (If not institution, give stri  116 PIGPEN POINT R		nber)		4b. City, Town, o	COWN		4c.	QUEEN A	
Funeral Director		267-90-4322	2 <b>X</b> F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of B (Month, D	ay, Year)	Cou	place (State or Foreign intry) ORIDA
land		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
Mary Ind	to	MD QUEEN AN	NE		OHE	ENSTOWN					1 ☐ Yes 2 X No
death with the Maryland me 23e or 28s-1 show Thutsh be revilled at	Director	10e. Street and Number	.,			10f. Zip Code			10g. Cit	zen of What Cou	intry?
ath w		104 PIGPEN POINT			2 1.0 1	21658		. 0.40		USA 14. Race - Ameri	and Indian
9 2 5	by Funeral	1 Never Married Married	Armed For 1 ☐ Yes If Yes, Giv	2 <b>X</b> No		Vas Decedent of H Yes, specify Cuba	an, Mexican Specify:	gin? (Specify Yes or N , Puerto Rican, etc.)	0-	Black, White	, etc.
5-003 72 hours naturel',		3 Widowed 4 Divorced	Year or Da	ates:	16a. Deced	ent's Usual Occup	ation		16b. Ki	MH] nd of Business/Ir	
ING 21215-0 be filed within 72 ho tal Hygiene. d other than "nature" event, tra Medical	Completed	(Specify only highest grade of Elementary/Secondary (0-12)		-4or 5+)	(Give	kind of work done OO NOT use retired	during most	of working			,
d 21.	Com	12	-0-		OWN	ER/OPERAT				TAIL STO	DRE
be fill be fill by out out	Be	17. Father's Name (First, Middle, Last)						r's Name (First, Middle			
Marylar  4 2 should be th and Menta 7 is marked traumatic ex	ဥ	DONALD CROMWELL  19a. Informant's Name/Relationship (Type	Print)		19b. Mailin	a Address (Street		r or Rural Route Numi			p Code)
		ALBERT L. BAKER/ HU	•		1			AD, QUEENS			
of Health of Health Inem 27		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Ren	and from 6	- 0	lace of Dispo emetery, cren	sition (Name of natory or other place	(e)	Date	20c. Lo	cation - City or T	own, State
Pages Pages Tent of ent: If It ury or o		* 4 □Donation 5 □ Other (Specify)	ioval from S	CHES	STERFI	ELD CEMET	ERY 1	1-28-2006	CEN	FREVILLE	, MD
Baltimore, permit. Pages 1 ar Department of Hea Importent: if item eny injury or othe		21. Signature of Funeral Service Licensee	69	1.	F		ELFENE	EIN & NEWN			IOME, P.A.
		23a. Part1. Enter the disea e, or complica shock, or heart lailure. List only one Immediate Cause (Final	tion that ca cause on ea	aused the death ach line.						us, 110	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (	or as a cons	ence of):	2 CEN 1.)					6M
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P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Dua to (	of as a consequ	rence of):	1000400					
eecute and I-trans	Examine	Cause (Disease or injury that initiated events c resulting in death) Last	Due to (	or as a consequ	uence of):						
8760, ate be executed hysician and the burial-transit	dicai E										
the by sa co	edic	0									
Geath certificate attending pt	Physician/Me	230. was decedent pregnant		come of pregna		Ectopic pregnancy	,		1	23d. Date of deliv	•
. 0 0 9	Sicia	in the past 12 months? 1 □ Yes 2 □ 10 □ Yes 2 □ 10 □ Yes 2 □ 10 □ Yes 2 □ 10 □ Yes		ant at time of de		Other (specify)				Month	Day Year
that the de ted by the a	Phy	Part II. Other significant conditions contri	outina to de	ath but not resu	alting in the ur	deriving cause giv	en in Part I.	23e. Did	tobacco u	se contribute to t	the cause of death?
<u>လ</u> ခို ညီရှိ	ed by							1 🗆	Yes 2	3 □ Proi	bably 4 Unknown
ecord law requir as been si 2 should	Completed							24a. Was		24b. Were auto	opsy findings available impletion of cause of
	E O							perf 1 ☐ Yes	ormed? 2. <b>∑4</b> √o	death?	
ysician: Th	Be	25. Was case referred to medical examiner?	- A - I			0.4		of Death (Check only		DADCETT	KD TE BOMK
Of Physic ruthis oural direction	٠ <u>۲</u>	1 Tes 2 Savo	pital: 1 □ Ir 28a. Date o		ER/Outpatien 28b. Time of			sing Home 5 Res			ER'S HOME
on on adding F. After of funer	tion	1 Natural 5 Pending 2 Accident investigation	(Mont)	h, Day Year)	Injury	28c. Injun Work M 1 [	k? Yes 2 □ N		now unjur	000011100	
DIVISION  or Attending after death. Director: Afte	Certification:	action :	28e. Place buildin	of Injury - At hong, etc. (Specify	me, larm, str	eet, factory, office			Street an wn, State		al Route Number,
Hospi 4 hou Funer ely fill	edicai Ce	29a. Certifier (Check only (Ch	: On the ba	isis of examinat							
To the Hos within 24 hd To the Fun completely	Med	29b. Signature and title of definier	and mann	er stated.		29c. Licens	e number		29d. Dat	a şigned (Month,	Day, Year)
7 × 00		M When	Cu			0	379	136	111	127/2	909
	8	30. Name and address perkin who com	eleted cause	ol death (Item	23a) (Type, 1	Barby V	War	e chef	v./	16 an	619
Stat Registra		31. Date liled (Month, Day, Year)	32. Re	egistrar's Signal	ture /	Sparks					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

For Stata Registra

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year **Physician** MARY CLEO BARRETT Vovember 27 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Memoria Easton
If Under 1 Year | If Under 24 Hrs. Hospita Talbot 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🗙 F 072-16-3940 84 BINGHAMTON, NY Director 10/06/1922 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD TALBOT **EASTON** 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ō 640 MECKLENBURG APT. 124 or iteme 23a 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐Yes 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: à If Yes, Give Year or Dates: Specify: 3 XWidowed 4 □ Divorced WHITE "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 RALPH J. HARRINGTON KATIE MAE GOULD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY LOU CANADY / DAUGHTER 713 POPLAR SCHOOL RD., CENTREVILLE, MD 21617 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. CHESAPEAKE CREMATION 4 ☐ Donation 5 ☐ Other (Specify) 11/28/2006 STEVENSVILLE, MD 21. Signature of Saneral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY STREET, CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPS15 **Physician** /Medical Due to (or as a consequence of): Examiner PNEUM ONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): the Hospital or Attending Physicien: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) physicien Physician/Medical ettending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ٥ in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient ဂ္ 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA his 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑Natural 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 Pending death. 2 Accident investigation 1 Tyes 2 No within 24 hours efter death To the Funerei Director: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name an a dress of person who completed cause of death (Item 23a) (Type, Print) S.V. Washington St., Easton, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 2 9 2016

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

**ORIGINAL** 

		For State Registrer	State of Ma	ryland /		ırtmen <i>tificate</i>			and M		giene, Reg. No.	711116	3960	)5
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/Medi Examir		4a. Facility Name (If not institution, give 63 Hingham Lane	street and number)			4b. City. Berl		Location o	of Death		4c. 0	County of Dea	ith	
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with the 3a or 28a	Funeral Director	10e. Street and Number 63 Hingham Lane				10f. Zip 218	Code 11					en of What C		
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paintinore, permit. Pages 1 and Department of Healt Important: If item 2 eny injury or other 2000.		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Specify		20b. Place ceme Metro	poli	tan C	rema	tory	11/2		Alex		a, Virgini	
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Physician: The law requires that the death certificate be executed  XX  Physician: The law requires that the death certificate be executed  XX  XX  XX  This certificate has been signed by the attending physician and upposite that director, page 2 should be detached for use as the burial-transit and certificate that the certificate has been signed by the attended for use as the burial-transit.	ilcai Examiner	23a. Part1. Enter the disease, or companies shock, or heart failure. List only of the shock of t	a	e. consequence	ce of):					respiratory a			Approximate Interval Between Onset and Death	
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To t With To t	×	29b. Signature and title of certifier	/at	MC	· ·		License	number	0	1		-	th, Day, Year)	
ν <sup>&gt;</sup>		30. Name of address of person of the state o					011	st.	5	11.35.	) ^ ~ ~ ·	MD	21801	
Sta Regist		Jones E. MART.  31. Date filed (Month, Day, Year)  NOV 28 2	32 degistra	r's Signature	No.	التامو								

DHMH 17 Rev 1/2001

223-46-4537

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 22, 2006 **Physician** 11:00P. M Ina Bloomberg /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rockville Casey House Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 👿 F 051-26-0910 75 Canada Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Rockville Maryland Montgomery Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 531 Lawson Way, #406 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Public School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Belle Weinstein Irving Freedlander ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 531 Lawson Way, #406 Rockville, Maryland 20850 Burton Bloomberg -husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Garden of Remembrance 11/27/2006 Clarksburg, Maryland 21. Signature of Funeral Service Ligensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Mon Small Cell Lung Cancer years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infraodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No 1 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To hospice After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

n 24 hours after death.

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> State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV

28

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams, D.O. Montgomery Hospice 6001 Muncaster Mill Road Rockville, Md. 20855 32 Registrar's Signature

Cynthia M Silliams DO-



1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

H0058032

29d. Date signed (Month, Day, Year)

November 24, 2006

			For State of Maryland / Dep	artment of Health and ertificate of Death		gienę/ () () () Reg. No.	39607
			Registrar  1. Decedent's Name (First, Middle, Last)	ranoate or Bount	2. Date of De	ath	3. Time of Death
	Physicia		Marjorie Catherine BROWN		Month Nov.	Day Year 29 2006	10:40 A <sup>M</sup>
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Т	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		th 9. Bi	rthplace (State or Foreign country)
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	o the	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	nth, Day, Year)
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	,		30. Name and address of person who completed cause of death (Item 23a) (Type			1 -/	
j/	1-2		Dr. Robert Guedenet 21 Wyand Dr	ive, Keedysville,	Marylan	.d	
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hou by Sydney Department of Health and Mental Hygiene.	Important: If Item 27 is marked other than "natura
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State of Maryland / Department of Health and Mental Hygiene													
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permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trai		21. Signature of Funeral Service	Licensee	<i>p</i>		2. Name and Addres					ERAL HOM	•	
9 E E 6		Alan C. Furun 210 W. MAIN ST., EMMITSBURG, MD. 21727											
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between		
Physician		Immediate Cause (Final disease or condition resulting in death)  Pulmonary by po plasic  Due to (or as a consequence of):									Onset and Death		
/Medical Examiner		Sequentially list conditions b. Riband vertebral anomalies											
	7											Oneday	
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
execu n and ial-trai	Exa	resulting in death) Last  Due to (or as a consequence of):											
rate be executed onlysician and the burial-transit	dical	d											
	Med	IC CCMALC.											
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Fetal death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □									23d. Date of de Month	livery Day Year	
ne de	/sic									_			
that the	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?				
uires signe	d by	Tetrology of Fallot with pulmonary atresia							1  Yes 2 No 3 Probably 4 Unknown				
w req	lete	Severe hydrocephalus. Renal agenesis						24a. Was an 24b. Were autopsy findings availabl			utopsv findings available		
The la e has age 2	m C								ormed?	prior to death?	prior to completion of cause of death?		
an: 7 tificat tor, pa	BeC	25. Was case referred to medical 26. Place of Death (Check only one)								) I LI Yes	s 21 <b>X</b> No		
ysici is cer direct	To B	examiner?									6 □Other (Spe	ecify)	
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		27. Manner of Death  1 XNatural 5 ☐ Pendin	28b. Time o Injury	28b. Time of Injury at Work? 28d. Describe how injury of					ry occurred	_			
	atic	2 Accident investigation				M 1 ☐ Yes 2 ☐ No							
or At fter d Direct in by	Certification:	3 Suicide 6 Could i 4 Homicide determ	e of injury - At ho ding, etc. <i>(Specif</i> )	injury - At home, farm, street, factory, office etc. (Specify)					Bf. Location (Street and Number or Rural Route Number, City or Town, State)				
pital ours a eral I		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
e Hos 24 hc Fun etely	Medical	(Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
To thi within To the	Me								te signed (Mon				
		▶ 800 M.D. RES-000							December 5, 2006				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Sarah Skelton. Nelson 2-133, 600 N. Wolfe St., Baltimore, MD 21287											
Sta Registr		31. Date filed (Month, Day, Year)		Registrar's Signa	ture	roles		-					
~		DEG 1 8	Protes										

			- For			ment of Health and			
			1 - State Registrar			icate of Death	Reg. (	2006	39609
	Physic /Medi		1. Decedent's Name (First, Middle, Last ELIZABETH	" CRUE	55		2. Date of Death Month	Day 2000	3. Time of Death
	Exami	ner	4a Facility Name (If not institution, give	street and number) 17-1 CEUTE	$\mathcal{R}$ $\frac{41}{L}$	o. City, Town, or Location of Death	h	4c. County of Death	INE
	Funeral Director		300 00 1000	7. Age (In yrs.		Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign intry)
	yland		Usual Residence of Decedent  10a. State  10b. County	10c. Ci	ty, Town or Locati	on			10d. Inside City Limits
	ith the Marylar or 28a-f show	ector	DE 3055E	X B	SIDGE	VILLE			1 ☐ Yes 2 ☐ No
	23a or	Funeral Director	RDI BOX 20	5A		0f. Zip Code	10g. (	Citizen of What Cou	intry?
9	after dez or items offiner a	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No	If Ye	Decedent of Hispanic Origin? (S s, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White	
5-0036	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show odical Examinar must be multibut at	ed by	3 Widowed 4 □ Divorced  15. Decedent's Edu	If Yes, Give Year or Dates:		Yes 2 No Specify:	10	Specify: WF	HITE
21215	within 72 ene. than "na	Completed	(Specify only highest grad		(Give kind	NOT use retired)	king 16b.	Kind of Business/Ir	ndustry
	filed with I Hygiene. other than		17. Father's Name (First, Middle, Last)		FIUL	18. Mother's Nam	ne (Firşt, Middle, Maid	on Sumame)\	116
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the M	To Be	WILLIAM WAL	LACE		MARY	(UNKN	OWN)	
_	init. Pages 1 and 2 should be filed within 72 hours after death with the Maryla affirment of Health and Mental Hygiene. cutant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinat must be multiled at a.	1 8	19a. Informant's Name/Relationship (T)	AUGHTER	19b. Mailing A	ddress (Street and Number or Ru	ral Route Number, City	or Town, State, Zip	21659
nore	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	Place of Disposition	n (Name of ry or other place) 12/	Date 20c.	Location - City or To	own, State
Baltimore,	permit. Pag Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens		22. Na	me and Address of Facility	AI HOME	1Detvi	ite, ite
ï	<u>0</u> 0 ≥ 0 0		23a. Part1. Enter the disease, or compl	ications that caused the deat	317	S. MAIN ST. FE	DEPALSA	URG, MC	21632 Approximate
	Physician /Medical	3 1	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on sch line.  Acute	Rev	al Failur	espiratory arrest,		Interval Between Onset and Death
H	Examiner			Lnan	uence of):				10 days
	uted I Insit	Examiner	Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Primas	RAD	egennatur	è Dom	1. Ara	10 comes
8760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequence	uboce of):	ger cur w	C \$5000		109013
9	tificate ig physi as the I	ledicai		1.					
О. Вох	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 SNo 9 □ Unknown	3c. If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 Ecto	opic pregnancy er (specify)		23d. Date of delive Month	ery Day Year
Δ.	es that igned b	by	Part II. Other significant conditions con	ntributing to death but not rest	ulting in the underl	ying cause given in Part I.	23e. Did tobacco	use contribute to th	ne cause of death?
ecords,	w requir been si should	ieted					1 ☐ Yes 2	<b>/</b> -	ably 4 Unknown
$\alpha$		Completed		-			autopsy performed?	prior to con death?	psy findings available impletion of cause of
Vital	Physician: 1 this certifical ral director, p	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	lospital: 1 Inpatient 2	FR/Outnatient 3	0+	th (Check only one) ome 5 Residence	6 DOther (0	-
ion of	ling After une	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how inju		//
Division	af or Attend after death Director: d in by the f	ertific	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, f	actory, office	28f. Location (Street a City or Town, Star	nd Number or Rura 'e)	l Route Number,
	To the Hospital or Atti within 24 hours after de To the Funeral Direct completely filled in by th	ledical C	29a. Certifier (Check only one) 1 Certifying Phys	sicien: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occion and/or investig	urred at the time, date and place, pation, in my opinion, death occur	and due to the cause(s	s) and manner as st ad place, and due to	ated. the cause(s)
1	To the To the comp	5	29b. Signature and title of ception	Mun	10	29c. License number	4 29d. Da	ate signed (Month, I	Day, Year)
•		-	30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Print)	cupobinatas	(x ====================================	ofma ma	77/60,
	Sta	te	31. Date filed (Mortin, Day, Fear)	32. Hedistrar's Signat	ure	Be washing on	or Eu	31001 102	4001
	Registr	ar	UEU , 200	6 per silver is	not for the				

		,	for State Registrar	State of Mar		artment rtificate			and M		iene	006	396	510
			Decedent's Name (First, Middle, Last	)						2. Date of Dea Month	th Day	Year	3. Time o	f Death
	Physici		Clara L	ucille Co	stantino					Novemb			1:50	) P M
	/Medio Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, T	own, or	Location o	f Death		4c. Co	unty of Death	)	
			24709 Showbarn C	ircle		Dama	scu	s			M	ontgor	nery	
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Months	Year Days	If Under a	Min.	8. Date of Birth (Month, Day	, Year)	Cou	place (State intry)	
	Director		579-26-9457	JM 28JF	80 Yrs.					Dec. 3,	1925	Wash	nington	ı D.C.
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation							10d. Inside C	City Limits
	within 72 hours after death with the Marylend ene. then "naturel", or items 23e or 28e-f ehow ite Moulcel Exercities trust be reciffied at	5	Maryland Montgom		Damasc								1 🗆 Yes	2 X No
	Ne M	ecto	10e. Street and Number			10f. Zip (	Code				Og. Citizen	of What Cou	intry?	
	with t	Funeral Director		Cimala		101. 2.10	208	72				.S.A.	,	
	a 23	eral	24709 Showbarn	12. Was Decedent Ev	ver in U.S. 13	Was Decede			gin? (Spe	cify Yes or No-		Race - Amer	ican Indian,	
	er de	Ë	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No		If Yes, speci	fy Cubar	n, Mexican	, Puerto F	cify Yes or No- Rican, etc.)		Black, White	, etc.	
36	Irs af	by F	3 □Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 Yes 2	□XNo	Specify:			Sp	ec <i>ity:</i> Wh	nite	
21215-0036	sture	ed	15. Decedent's Edu		16a. Dece	dent's Usual	Occupa	tion			16b. Kind	of Business/I	ndustry	
15	n n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+	life.	kind of work DO NOT use	retired)	u <i>ring m</i> osi	t of workir	ng				
77	d within giene. er then	Eo	10	College (1º40) 34		memake	er				Ow	n Home	3	
ਰੂ	E P E	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle,	Maiden Sui	mame)		
<u>a</u>	Q 20 D	To B	Joseph O'Bryh	im				E11	lise	Wilbu	r			
Maryland	A B E E	_	19a. Informant's Name/Relationship (T)							l Route Numbe				20072
	and 2 eaith a m 27 is		Lisa DeRosa - Dau	ghter	1011	2 She	Lldr	ake (	rcl	e, Dam	ascus	, Mary	land 2	20872
ē,	of Healt Item 2		20a. Method of Disposition	State State	20b. Place of Dispo cemetery, cre	osition (Nam matory or oti	e of her place	9)	D	ate	20c. Locat	ion - City or 1	Town, State	
Ë			1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Conation 5 🖾 Other (Specify,	Entombment	Gate of	Heave	n Ma	usole	eum	11/28/0	6 Sil	ver S	oring,	Md.
Baltimore,	permit. Pege Depertment Importent: If any Injury o		21. Signature of Foneral Service Hoens	* Willia	) M	oleswo	orth.	-Will	iams	P.A., Damascu	Funer	al Hom	ne 1 2087	72
			23a, Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused t	he death. Do not en	ter the mode	of dying	, such as	cardiac o	r respiratory ari	est,		Approxima Intervat Be	ate
	Physician	ŀ	Immediate Cause (Final	Lun		inon	11						Onset and	Death
	/Medical		disease or condition resulting in death)	a	onsequence of):	71.01	4						mont	h 5
	Examiner													٠, ٦
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	uted d ansit	声	cause. Enter Underlying Cause (Disease or injury that initiated events	С.										
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.89	ificat g phy as th													
Вох	death certificat e ettending phy id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		□Ectopic pre	annancy				23d	Date of deli	•	
m	death e ette d for	<u>C</u>	in the past 12 months?	4 Pregnant at ti		Other (spe						Month	Day	Year
0	by the detached	hys	9 Unknown	9 Unknown							_			
٦,	g	by P	Part II. Other significant conditions co	ntributing to death but	t not resulting in the t	inderlying ca	iuse give	en in Part I.	•	23e. Did to	bacco use	contribute to	the cause of	death?
g	quires n slgn ald be									J. A.	es 2 🗆 N	lo 3□Pro	obably 4	]Unknown
Records,	w require been sl should l	Completed								24a. Was		4b. Were au	topsy findings	available
Re	The law	Ę								autop perfor		death?	completion of 2 No	cause or
a		CO	25. Was case referred to medical					26 Place	of Death	(Check only or		1 103	20 140	
Vital		0	evaminer?	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatie	nt 3 DO.	A Othe	-		ne 5 Resid		Other (Spec	oftv)	
o		2:1	27. Manner of Death	28a. Date of Injury (Month, Day			Bc. Injury Work			28d. Describe h			,	
0	ding I h. After funer	후	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	м		Yes 2□	No					
Si	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be	289. Place of Injur	ry - At home, farm, st	reet, factory,	office			28f. Location (S		lumber or Ru	ral Route Nu	mber,
Division		Certification:	4 Homicide	building, etc.	(Specify)					City or Tow	n, State)			
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	vsician: To the best of iner: On the basis of and manner state	examination and/or in	th occurred anvestigation,	at the tim	ne, date an pinion, dea	nd place, a th occurre	and due to the ded at the time, d	ause(s) an date and pla	d manner as ace, and due	stated. to the cause	(s)
	within 2 To the comple	Mec	29b. Signature and title of certified	A		29c	License	number					n, Day, Year)	
)	F ₹ 50		11/1/1/				02	313	38	n	lovem	ber 2	7, 20	06
_	•		30. Name and address of person who d	completed source of de	ath (Itam 22a) (Tuna								,	
7	)		Daniel A. Jaller		.9500 Amar		riv	e - #	В,	Germant	own,	Maryla	ind 20	)874
		ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature			_ "	_,					
	Regist	rair	NOV 2 9 2	UUD	a K	mach	,							

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ORIGINAL

			1 _ State	State of Marylan	d / Depa	artmer	t of Heal	lth and N ath		giene Rog. No.	006	39611	
			Registrar  1. Decedent's Name (First, Middle, Last)						2. Date of Dea			3. Time of Death	
	Physicia		NANNIE LEE	CUMBERLAND					Novembe:	$r \stackrel{ extsf{Day}}{21}$	2006	9:10 p <sup>M</sup>	
	/Medic Examin		4a. Facility Name (If not institution, give str 7 Ruth Avenue		<u> </u>		Town, or Local	ation of Death			ounty of Dea Oward	th	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)			Jnder 24 Hrs. ours Min.	8. Date of Birtl	h Vearl	9. Bir	thplace (State or Foreign ountry)	1
	Director		230-30-1919	M 2√2 F 81	Yrs.	Months	Days Ho	ours Min.	June30,	1925	Ví	rgínia	_
7	2		Usual Residence of Decedent  10a State 10b County	10c Cit	y, Town or Lo	acation						10d. Inside City Limits	_
, elvo	how	_	,	106. 611	Laure							1 ☐ Yes 2 No	
44 00		Directo	Maryland Howard		Laure	7	- Code			10a Citiza	en of What C		_
G Z I Z I 3-0030	23a or 2	al Dire	7 Ruth Avenue			101. 21	20723			Uni	ted St	ates	
0		Funeral	11. Marital Status	2. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Dece If Yes, spe	dent of Hispar ecify Cuban, M	nic Origin? (Sp exican, Puerto	ecify Yes or No- Rican, etc.)	14	<ol> <li>Race - Am Black, Whi</li> </ol>	erican Indian, ite, etc.	
	i, or it	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 🗆 Yes	2.XNo Sp	ecify:		5	Specify: W	hite	
	nature lead	Completed	15. Decedent's Education (Specify only highest grade	ation completed)	/Give	kind of w	al Occupation	g most of worl	king	16b. Kin	d of Business	s/Industry	
	Med "r	pje	Elementary/Secondary (0-12)	College (1-4or 5+)	lite.	DO NOT	ise retired)			۸rh	itron	Corn	
V .	ygien t.	် ပ			Data	CHLEY	Proce		e (First, Middle,			COLP.	_
9	perinit. Pages 1 and 2 should be filed writtin 7.2 hours after deet, with the way yar, perintent of Health Montal Hygiene. Importment of Health Montal Hygiene. Importment: if them 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	To Be	17. Father's Name (First, Middle, Last) Jerome Franklin Ca	mpbell					n Duncan		umame)		
~ <	h and M h and M 7 ie mar trsumat		19a. Informant's Name/Relationship (Type Ann I. Wilson -dau						ofton, M				
υ.	i and Health em 27 ther ti		20a, Method of Disposition	20b. F	Place of Disp	osition (Na	me of		Date			r Town, State	
5	rages nent of l ant: If It ary or o		1 XBurial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, cre	matory or Memor	other place) •ial Ce	meterv	11/28/2	2006 <sub>1</sub>	ebanon	, Virginia	
	ntant neury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License					-	-				_
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	husisian		shock, or heart failure. List only one Immediate Cause (Final	Extensive	Small	Ce11	Lime C	ancer				Onset and Death 3 months	
	hysician /Medical		disease or condition resulting in death)	Due to (or as a consec		OCII	Edite C	anoci					_
E	Examiner												
		Jer	Sauuentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	(uerice of).								
	cuted nd ransit	Examiner	that initiated events c.										
ĵ	en ar en ar irial-t	EX	resulting in death) Last	Due to (or as a consec	quence of):								
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ğ	death ce le ettend ad for us	Physician/Me	23b. Was decedent pregnant in the past 12 sponths?	lc. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta	al death 3		pregnancy			2	3d. Date of d Month	elivery Day Year	
	the e	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of of 9☐Unknown	death 5	Other (	specпу)						
Z.	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions conf	ributing to death but not res	sulting in the	underlying	cause given in	Part I.	23e. Did t	obacco us	e contribute	to the cause of death?	
ras,	signe signe	d by							1₹.	Yes 2	]No 3 □ F	robably 4 ∐Unknown	1
ecor	requ	Completed							24a. Was	an	24h Were	autonsy findings available	Α.
ě	elay has	ם							autor perfo	osv	death's	autopsy findings available completion of cause of	
	ician: The l certificete ha rector, page		or W				06	Diagonal Dog		-	1 ∐ Y€	es 2□No	-
VItal	sician: certific irector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:	TER/Outpatio	vot 2□ [	Other		ome 5 Resident		□Other /Sc	acifu)	
ō	Physical distribution	5 5	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time		28c. Injury at Work?	4 140/3/191	28d. Describe			ochy)	_
Ö	ding f th. After tuner	ţ	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	М		2  No					
DIVISION	Attending Physician: r death. ector: After this certific by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Ptace of Injury - At h building, etc. (Speci	nome, farm, s	treet, facto	ory, office		28f. Location (		Number or I	Rural Route Number,	_
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	To the Hospital or Attendi within 24 hours after death. To the Funsral Director: A completely filled in by the t	edical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kn er: On the basis of examin- and manner stated.	owledge, dea ation and/or i	th occurre	d at the time, o	date and place on, death occu	, and due to the irred at the time,	cause(s) date and	and manner place, and di	as stated. ue to the cause(s)	
	ithin ; o the	Mec	29b Signature and title of certifier			2	9c. License nu					nth, Day, Year)	_
	10		) (Jaloulo 1/20	ue, MD			D4670	)4		Nove	mber 2	22, 2006	
	U			malated source of death (Ite	m 23a) (Type	e, Print)						1 00==:	
			Mutombo Kankonde,	M.D. KP 1221	Merca	antil	e Lane	Upper	Marlbor	o, Ma	ryland	1 20/74	
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	rese	9						

			1 - For State Registrar	State of Mary		artmen rtificat			and M		giene Reg. No		6	39	612
I	Physic	ian	1. Decedent's Name (First, Middle, Last,  Margaret Helen	Chick						2. Date of De. Month Novemb	ath Da	¥2 2%	ar_		e of Death
	/Medi Exami		4a. Facility Name (If not institution, give			4b. City.	Town, or	Location of	f Death	Novemb	7	23, ZU		11	:00A M
	LAGIIII		5503 Belva Street	·			ham					Prince		orge	e's
	Funeral Director		5. Social Security Number 6. Set 579-34-1954  Usual Residence of Decedent	7. Age (In	yrs. last birthday, 79 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da August	4,1	9. 927 W	Birthpl Count ash:	ace (Sta ry) ing t	on, DC
	Maryland a-f ehow	ctor	10a. State 10b. County Maryland Prince Ge		c. City, Town or Lo anham	ocation							10		e City Limits ∕es 2∑ No
	13a or 28	Funeral Director	10e. Street and Number 5503 Belva Street			10f. Zip	Code 207	'06				izen of Wha		-	
9036	nit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland artment of Heelth and Mental Hyglene. artment of Heelth and Mental Hyglene. ortent: if item 27 is marked other then "naturel", or items 23a or 28a-f show ortent: other treumatic event, the Mudical Examiner must be notified at the machine as a second of the machine	Ď	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	in U.S. 13.	Was Deced If Yes, spec 1 ☐ Yes		spanic Orig n, Mexican, Specify:	gin? (Spe Puerto F	offy Yes or No- Rican, etc.)		14. Race - A Black, V Specify:	/hite, e		1,
Baltimore, Maryland 21215-0036	filed within 72 h Hygiene. other then "natuent, the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (9-12)	cation completed) College (1-4or 5+)	16a. Dece (Give life. Homema	dent's Usua kind of wor DO NOT us aker	l Occupa k done d e retired)	tion uring most	of workin	g		ind of Busine		ustry	
yland	2 should be file and Mental Hyg Is marked othe sumatic event,	To Be C	17. Father's Name (First, Middle, Last)  Jeremiah Driscoll					Hele	en M	(First, Middle,	t S	Stanbu:	,		
, Mar	es 1 end 2 sh of Heelth and litem 27 Is m r other treum		19a. Informant's Name/Relationship (Ty) Walter E. Chick -h	usband	5503	Belva	Str	eet I	or Rural Lanha	Route Numbers, Mar	r, City o y <b>l</b> ar	or Town, Stat nd 2070	e, <i>Zip (</i>	Code)	
imore	Pages 1 ment of Hi ent: if iter ury or oth		20a. Method of Disposition  1	emoval from State	ob. Place of Dispo cemetery, crei Cedar Hil	matory or of	her place	y 11		2006 S		cation - City $1$ and,			
Balt	permit. Pag Department Importent: I eny injury o		21. Signature And Serve License	Mouthy	¥ 42	HUU PC	waer	MILLI	L Koa	Funera d Belts	SV1.1	ome, Pa	A ary]	Land	20705
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or bear failure. List only on the time disease or condition resulting in death)  Sequentially list conditions	Failure to Orasa cor Senile De	death. Do not ent to Thrive isequence of):	ter the mode	of dying	, such as c	cardiac or	respiratory ari	rest,		1	Approxir Interval	nate Between nd Death AT
8760,	death certificate be executed e attending physician and of for use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor											
P.O. Box 68	ath certific attending p	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 □ Yes 2 ☑ No 9 □ Unknown	ic. If yes, outcome of pre 1 Live birth 2 1 4 Pregnant at time 9 Unknown	Fetal déath 3	]Ectopic pre ] Other (spe						23d. Date of Month		/ Day	Year
	law requires that the de as been signed by the 2 should be detached	Ď	Part II. Other significant conditions con	nbuting to death but not	resulting in the u	nderlying ca	use giver	n in Part I.			bacco u es 21	se contribute XNo 3□			of death?
	The lar ete has page 2	Completed							_	24a. Was a autops perform	SV.	prior	o com	pletion o	gs available f cause of
Ĭ.	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	ospital:			! Othor			Check only on					
ō	Phys er this eral di	5.	27. Magner of Death	1 ☐ Inpatient  28a. Date of Injury  (Month, Day Yea.	2 ER/Outpatien 28b. Time of		Ic. Injury a	4 🗆 Nuis		e 5 Reside			pecify)		
ion	Attending r death.	atio	1 ⚠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	r) Injury	М		es 2 □ No				,			
Divis	tal or Attencts after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, streecify)	eet, factory,	office		28	of. Location (Si City or Town	reet and n, State,	d Number or	Rural I	Route N	umber,
	To the Hospital or Attending Phyminis 24 hours attended to the Funeral Director: After the completely filled in by the funeral	Medicai	one)	cian: To the best of my er: On the basis of exam and manner stated.	knowledge, death nination and/or inv	estigation,	in my opii	nion, death	place, an	at the time, d	ate and	place, and d	ue to ti	ne cause	
)	I)	2	29b. Signature and title of certifier	Un			D2:	2780		.2		e signed (Mo vember			
	E gCa		30. Name and address of person who cor Peter Schissler, M	.D. /500 Gr	eenway C	Print) enter	Dri	ve,#4	30 G	reenbel	t,	Maryla	ind	2077	70
1	Sta Registr	_	31. Date filed (Month, Day, Year) NOV 2 8 200	32 Registrar's Si	griature A	ale)									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** VOV3 M/202 28, 200 VBR /Medical 4c. County of Deat 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months **Funeral** Min 1 □ M 2 🛛 F 71 Yrs. 10 Maryland 1935 Nov. Director 214-34-0725 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Hagerstown Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21740 17941 Pin Oak Road by Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) School 1 Aide 12 O 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) Be and Mental Myrtle Benson John L. Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17941 Pin Oak Road, Hagerstown, Md. 21740 Health a Robert W. Davis - Husband item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 □ Cremation 3 □ Removal from State Hagerstown, Maryland Cedar Lawn Mem. Park 12/2/06 4 □ Donation 5 □ Other (Specify) Minnich Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Kali 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final MONTHS Physician heonic disease or condition resulting in death) /Medical ue to (or as a conseque re of): Examiner mmTH STROKE Sequentially list conditions, if any, leading to infriediate cause. Enter Underlying Cause (Disease or injury Due to (or se a consequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to þ 2☐No 3☐ Probably 4☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 Be Medical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral within 24 hours a To the Funeral L

Baltimore, Maryland 21215-0036

							1□ Yes	2 ☑ No	1 ☐ Yes	2 □ No
5. Was case referr	red to medical				26. Place o	of Death (C	check only o	one)		
examiner? 1 ☐ Yes 2 ☐	No I	Hospital:	2 ☐ ER/Outpatient	3 DOA	Other: 4 Nurs	sing Home	5 ☐ Resi	dence 6	☐Other (Specif	<i>(y)</i>
7. Manner of Death 1 Matural 2 Accident	1 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c.	Injury at Work? 1 ☐ Yes 2 ☐ No		f. Describe	how injury	occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		at home, farm, street ecify)	t, factory, o	ffice	28f.	Location ( City or To			al Route Number,
9a. Certifier (Check only one)	1 ☐ Certifying Ph 2 ☐ Medical Exar	nysician: To the best of my miner: On the basis of exan and manner stated.	knowledge, death o nination and/or inves	ccurred at stigation, in	the time, date and my opinion, death	place, and h occurred	d due to the at the time,	cause(s) , date and	and manner as s place, and due t	itated. o the cause(s)

29b. Signature and title of certifier

29c. License number RES-000 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 NICHOLAS T. NELSON

Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

03H-5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39614 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 9:00 Pin Ruby Dick 6 erfrude 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Hagerstown Coffman Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1□M 2CXF Maryland 217-42-8998 95 June 19,1911 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County r than "natural", or Iteme 23a or 28e-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Williamsport Maryland Washington Direct 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21795 USA 16396 Spielman Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes XX No Specify: Baltimore, Maryland 21215-0036 Specify: White þ XXWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Home Housewife 12 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 Is marked oth any july or other traumatic event ping. Be Della Mae Drenner Charles Raymond Renner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21740 521 Salem Avenue Hagerstown, Maryland Jeanette B. Dick - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition XX Burial 2 Cremation 3 Removal from State Greenlawn Mem. Park Dec.1,2006 Williamsport,Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se OSBOTATE AFTEN HOME, P.A. 425 S. Conococheague St. Williamsport, MD 21795 Part1. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on excellence. Approximate interval Betwe weller Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner igned by the ettending physicien end be detached for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 1 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed hes this certificate 1 Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Yes 2131 2 ☐ ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After Injury Attending 1 Matural 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 20a) (Type,

State

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

M Shuzis 32. Registrar's Signature

			State of Maryland / Department of Health and Mental  1- For State Registrar  Certificate of Death	Hygiene Reg. No: 006	39615
	Physici	an	Mon	e of Death oth Day Yea	3. Time of Death 9;15 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of De	ath
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date	e of Birth 9. B	irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	22, 1940	
	Marylan f show	tor	10a. State 10b. County 10c. City, Town or Location HAGERSTUWN		10d. Inside City Limits 1 Yes 2 □ No
	death with the Maryland ms 23e or 28e-f show rmust be notified at	Funeral Director	10e. Street and Number 317 HENRY AVE 21740	10g. Citizen of What (	Country?
936	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-1 show other treumatic event. It is Modical Everal art mast be notified at	þ	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	etc.) Black, Wi	nerican Indian, nite, etc.
1215-0036	within 72 housing.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  CHEF	16b. Kind of Busines RESTAUR FOOD SE	ANT
nd 2	be filed tal Hygid d other event, I	Be	17. Father's Name (First, Middle, Last)	Middle, Maiden Sumame)	
Maryland	12 should be filed within hand Mental Hygiene. 7 is marked other than "treumatic event, treumen	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route	Number, City or Town, State	
-	iges 1 and 2 it of Health a it Item 27 is or other tre		RYAN EVANS (SON) 755 W. WASHINGTON ST.  20a. Method of Disposition    Date   Disposition   Date   Disposition   Date   Disposition   Dispositi	20c. Location - City of	or Town, State
Baltimore	permit. Pages I Department of H Important: If Ite any injury or ot once.		21. Signature of Funeral Service Licensee  When the following post HILV COM. DEC. 1, 200  22. Name and Address of Facility GARY  HONE 59 N. CANNON	L. ROLLINS	PULLERK
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirations, shock, or heartfailure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  A cardwise privatory failure to (or as a consequence of):  Due to (or as a consequence of):	atory arrest,	Approximate Interval Between Onset and Death
O. Box 68760,	requires that the death certificate be executed een signed by the attending physicien and hould be detached for use as the burial-transit	Completed by Physician/Medical Exa	resulting in death) Last  Due to (or as a consequence of):  d.	23d. Date of d Month	
ds, P.O.	signed by	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e  Diahetes Meliture II	a. Did tobacco use contribute  1 ☐ Yes 2 ☐ No 3 ☐ i	to the cause of death?
Vital Records,	The law ate has b page 2 sl	Complete	Diabetes Mellitus II Peptic Acid Disease  248	a. Was an autopsy performed? Yes 2 500 1 24b. Were death?	
Vita	Physicien: this certific ral director,	To Be (	25. Was case referred to medical examiner?	conly one) ☑Residence 6 □Other (Sp	ecify)
Division of	ling After fune	Certification: T		scribe how injury occurred	
Divis	after de after de Directo	ertific	3 Suicide 4 Homicide  Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ation (Street and Number or i or Town, State)	Rural Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier  (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due and manner stated.		
	To the To the comp	M	29b. Signature and titled certifier  29c. License number  D 35 497	29d. Date signed (Mo.	
03	H-2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  [ANVIR A. PASHA, MD 1122 OPAL CT. HAGE	ERSTOWN.	MD 21740
	Sta Registr				

State of Maryland / Department of Health and Mental Hygiene Reg. No. UU6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year November 24, 2006 **Physician** 7:10 P J. Grimes Eva /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery General Hospital Montgomery 01nev 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, May 3, If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1□M 2□¥F Months Days Hours Mary Land 83 Yrs. 217-18-7210 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location rthen "neturel", or Items 23a or 28a-f ehov the Medical Examinat must be notified at 1 Yes 2 No Mount Airy Director Maryland Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21771 808 Roller Coaster Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 1 end 2 should be Health and Mental Bertha Mae Blank George Flook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 s
Department of Health ar
Important: If item 27 ie
any injury or other trau 4939 Tall Oaks Drive, Monrovia, Maryland 21770 Charles W. Grimes - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 11/30/06 Rockville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune al Service Licensee Molesworth williams P.A., Funeral Home overl 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Failure /Medical Due to (or as a consequence of): Examiner Hemoptysis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Cther (specify) 9 Unknown 9 I Inknown been signed be should be detailed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Lung Mass Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No Syncope hes : After this certific s funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No Director: A in by the f investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours e To the Funerel [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 26, 2006 D0061681 30 Name and and who completed cause of death (Item 23a) (Type, Print) Robert Kirkcaldy, M.D. 10101 Prince Philip Drive, Olney, Maryland egistrar's Signatura 31. Date filed (Month, Day, Year) 2006 32. State

DHMH 17 Rev 1/2001

Registrar

			1 - State Registrar  State of Maryland /	Depar		Health a		tal Hygi	-	39618
			1. Decedent's Name (First, Middle, Last)					ate of Death		3. Time of Death
	Physic /Medi		Robert Wareen Harris					Nonth	2 2006 Yea	6:35 p M
	Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location of	Death		4c. County of De	
		*	Ruxton Health of Denton		Dentor				Caroli	
	Funeral Director		5. Social Security Number  216-72-9603  6. Sex  1 M M 2 F 7. Age (In yrs. last bill 7. Age (In y		If Under 1 Year Months Days		Min.	ate of Birth Month, Day,	9. B	inthplace (State or Foreign Country)
			Usual Residence of Decedent				y an	n 22 1	933 [Or]	Lando, FL
	72 hours after death with the Maryland netural', or Items 23a or 28e-f ehow disal Examinar must be roditled at	1.	10a. State 10b. County 10c. City, Tow	wn or Loca	ation					10d. Inside City Limits
	the Marylan r 28e-f ehow rollilled at	Director	Maryland Caroline Denton	n						1 ☐ Yes 2 No
	ith th	Oire	10e. Street and Number		10f. Zip Code			10	g. Citizen of What	Country?
	death w	rai	420 Colonial Drive		21629				.S.A.	
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Wa	as Decedent of Yes, specify Cub	Hispanic Origi pan, Mexican,	in? (Specify Puerto Ricar	res or No-	14. Race - An Black, Wh	nerican Indian,
36	rs after of ter	by F	1 X Never Married 2 Married 1  Yes 2 X No If Yes, Give 2 Yes or Date:		⊇Yes 2 <b>X</b> No			,	Specify:	White
21215-0036	72 hours 'netural', dical Exa	ed		2 Dacada	nt's Usual Occu	nation				
15	_ * 21	piet	(Specify only highest grade completed)	(Give kii life. DC	nd of work done O NOT use retire	pation i <i>during</i> m <i>ost d</i> ad)	of working	16	6b. Kind of Busines	s/Industry
212	filed within all Hygiene. other than "I yent, The Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	disa		,			N/A	
b	e filed al Hygid other vent, I	BeC	17. Father's Name (First, Middle, Last)			18. Mother	s Name (Firs	t, Middle, Ma	aiden Sumame)	
/lai	ould be Mental arked o	To	Lewis A. Harris, Sr.			Els	ie Mac	Farla	ne	
Maryland	s 1 and 2 should be filed within if Health and Mental Hygiene item 27 is marked other than other traumatic event, the Mental Mental items.		19a. Informant's Name/Relationship (Type, Print) 19b	b. Mailing	Address (Street				City or Town, State,	. Zip Code)
	and ealth in 27		Berry Barrell, legal guardian 10	00 Sc	hauber	Road;	Cheste	rtown	Marylan	d 21620
ore	ges 1 au t of Hea If item or othe		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of cemeter	of Disposit ery, crema	ion (Name of tory or other pla	ice)	Date	20	oc. Location - City of	or Town, State
Ë	mit. Pag partment cortant: injury es.	1		ly Ce	emetery	12	2/1/20	06 F	Ridgely,	Maryland
Baltimore,	permit. Pages Department of H Important: If its any injury or of		21. Signature of Suneral Service Licensee		Name and Addre		1			
	Ø □ = # O		Magn (fley	PO	Box 160	Green	sboro,	MD 21	al Home,	PA
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter	the mode of dyi	ng, such as ca	ardiac or res	piratory arres	t,	Approximate Interval Between
	Physician	ď u	Immediate Cause (Final disease or condition	In	cumon	La				Onset and Death
	/Medical Examiner		resulting in death)  Due to ( r as a consequence	of):						C/1 (1703)
п		h 1	Sequentially list conditions. b. 500000		nha					7 Sycans
	ted nsit	nin	Sequentially list conditions, if any leading to min solate cause. Enter Underlying Cause (Disease or injury	01):						3
	xecu and	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence	of):	_					
760	ate be executed hysician and the burial-transit	cai E								
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit		d.							
Вох	leath certifical attending phy ifor use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy						23d. Date of de	alivery
	that the death	lcia	in the past 12 months?  1 Ves 2 No.  4 Pregnant at time of death		ctopic pregnancy other (specify)	y 			Month	Day Year
P.0	t the by th tache	hys	9 ☐ Unknown							
	igned be det	by P	Part II. Other significant conditions contributing to death but not resulting in	in the unde	erlying cause giv	en in Part I.	2	3e. Did tobac	cco use contribute i	to the cause of death?
ord	w require been si should b							1 🗌 Yes	2 \\ No 3 □ P	robably 4 Unknown
Records,	e law r has be je 2 sh	ple					2	4a. Was an	24b. Were a	utopsy findings available
_		Completed					_	autopsy performe □ Yes 2 •	d? death?	completion of cause of s 2□ No
Vital	Phyaician: this certificatal director,	Be (	25. Was case referred to medical examiner?			26. Place of	Death (Che		7.10	0 20,110
of \	hyai his o	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	utpatient	3□ DOA Oth	er: 4 ursi	ing Home 5	Residenc	e 6 □Other (Spe	ecify)
	ing P	Certification:	1 Natural 5 Pending (Month, Day Year) I	Time of Injury	28c. Injur Wor	y at k?	28d. D	escribe how	injury occurred	
Sio	vttendii death. ctor: A y the fu	cat	2 Accident investigation			Yes 2 ☐ No				
Division	or Attending after death. Director: After in by the fune	in the	4 Homicide determined 28e. Place of Injury - At home, fa	arm, street	, factory, office		28f. Lo	cation (Streetly or Town, S	et and Number or Fi State)	lural Route Number,
	pitel ours a eral I		29a. Certifier 15 Sertifying Physician: To the best of my knowledge				1			
	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier  (Check only one)	e, death od nd/or inves	ccurred at the tir tigation, in my o	ne, date and p pinion, death	olace, and du occurred at t	e to the caus he time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	othin othin ompl	₩	29b. Signature and title of certifier		29c. Licens	e number		29d.	Date signed (Mon	th. Dav. Year)
	->=0		, ep way		Don	6168	37	11	12=101	
		1	30. Name and address of person who completed cause of death (Item 23a) (	(Type, Prin		, , ,			1-1100	
				mad		vic.	chost	9 N	ND 216	9
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		- 4000	v.C.	<u> </u>		- 010	
	Registr	ar	NUV 2 9 2006	pain a state	e.					
DH	MH 17 Rev 1/20	201	The second secon	Wall of the	d					

			Please I	• •			. Ensure All (	•	9	е.
			For State	State of Ma		rtificate of	Health and Mer		7000	39619
			Registrar  1. Decedent's Name (First, Middle, Last)			Tillicate of		Reg Date of Death	. No.	3. Time of Death
П	Physici		THOMAS	=	4	I.TO H	ins SRING	Month		ear
ļ	/Medio Examin	_	4a. Facility Name (If not institution, give s	street and number)			or Location of Death	DEMOE	4c. County of	
	aaiiiii		CHESTER RIVER	HOSPITA	L CENTER	CHE	STERTOWN	,	KE	NT
	Funeral		5. Social Security Number 6. Sex	7. Age	ə (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8	Date of Birth Month Day, eb 16 1	earl 9	Birthplace (State or Foreign Country)
Н	Director		214-34-6138	109	Yrs.		F	eb 16 1	93/ M	laryland
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Man,	ţ	Maryland Kent		Chesterto	wn				1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of Wha	at Country?
	23a	la l	303 Hoffecker Road			21620			U.S.A.	
	er de	Funeral		12. Was Decedent I	Ever in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Specify Dan, Mexican, Puerto Ric	y Yes or No- an, etc.)		American Indian, White, etc.
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 Yes 2 N If Yes, Give Year or Dates:	10	1 ☐ Yes 2X No	Specify:		Specify:	B1ack
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Iteme 23a or 28a-f show that the Madical Examinar must be notified at	ted	15. Decedent's Educ	cation	16a. Dece	dent's Usual Occu	pation	16	b. Kind of Busir	ness/Industry
2	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	+)		during most of working			
7	lygier her th	ပ်	10 17. Father's Name (First, Middle, Last)		assen	bly work	18. Mother's Name (F		uto ind	ustry
anc	od of	Be	William Joseph Hut	chine			Minnie E.			_
2	Shoule nd Me mark mati	ဥ	19a. Informant's Name/Relationship (Type		19b. Maili	ng Address (Street	t and Number or Rural R			
	nd 2 alth ar 27 is r trau		Thomas E. Hutchins	, Jr./ so	n PO E	x 46 303	Hoffecker	Road Ch	esterto	wn, MD 21620
e,	of Hei		20a. Method of Disposition		20b. Place of Dispo cemetery, cre					ty or Town, State
Ē	Page ment ant: if ury o		1 XBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			tery 11/27/	2006 G	oldsbor	o, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: if item 27 is marked other than "natural; or iteme 23a or 28a-f show any injury or other traumatic avant, the Madical Examiner must be notified at ADEs.		21. Signature of Funeral Service License	9	2:	2. Name and Addre				
	20 = # d		23a. Part1. Enter the disease, or compli	May 1	PC	Box 160	Greensboro	, MD 21	639	
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each lir	ne.	ter the <i>m</i> ode or dyl	ing, such as cardiac or re	espiratory arrest		Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	Cop	a consequence of):	stage				7 days
	Examiner			Con	a consequence on.	such d	Failer			7000
		ner	Sacuentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	onsequence of):					0
	w requires that the death certificate be executed been signed by the attending physicien and should be delached for use as the burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Ac	te M	journ	- Int	uretion	o	l days
60,	cien a	alE	resulting in oeasty cast	Due to (or as	a consequence of):					1
687	physics the I		d							
Box (	certif nding use at	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome					23d. Date of	of delivery
ă.	Attanding Physician: The law requires that the death certificate in death.  •ctor: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	Physician/Medi	in the past 12 months?	4☐Pregnant at		⊒Ectopic pregnand □ Other (specify) _	;y		Month	
<u>Р</u> О	t the by the tache	hys	9 □ Unknown	9□ Unknown						
s,	es the	व	Part II. Other significant conditions con							ute to the cause of death?
g	een s	Completed	Typeal Dick	etis M	11/400	12 6. 2/2	muzica, -	1 □ Yes	2□No 3[ ——	Probably 4 Unknown
ě	e 2 st	nple						24a. Was an autopsy	prio	re autopsy findings available or to completion of cause of
E H	r: The							performe 1 □ Yes 2 \		Yes 25 No
<u>=</u>	siciar certif irecto	) Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:		ott no. Ott	26. Place of Death C		a 6704	(0. 4)
ō	Phy er this eral d	2	27. Manner of Death	28a. Date of Injur		nt 3LI DOA	4 U Nursing Home	5 L Residence		(Ѕресіту)
<u>o</u>	ath. r: Afte	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Da)	/ Year) Injury		ork? ]Yes 2□No			
Division of Vital Records,	r Atta er der recto	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju-	ury - At home, farm, st	reet, factory, office	28f.	Location (Street)		or Rural Route Number,
	itato irs aft ral Di ited in									
	Hosp 24 hou Fune Hely (i	edlcal	29a. Certifier Certifying Physical (Check only one)	sician: To the best oner: On the basis of and manner sta	examination and/or in	th occurred at the till exestigation, in my	ime, date and place, and opinion, death occurred a	I due to the cau: at the time, date	se(s) and mann a and place, and	er as stated. I due to the cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely tilted in by the funeral director, page 2	Med	29b. Signature and title of certifier	and marrier Sta		29c. Licen	se number	29d	. Date signed (/	Month, Day, Year)
}	->-0		1 40	- M	D	D	51735		11/211	06
			30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Type,					-
			Fradarick Dalboy	6602 Chu	rch Hill R	oad, Cher	stertown, M	2162	20	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	÷				

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental I

Kathy Lorraine I		1- For State	ate of Maryla		artment of		d Mental	, 5	21	006 3962
Physici	an/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Vers								
Medical Exam	iner			ımber)		4b. City, Town, or	Location of De			1425 1115
		728 Clopper Road Apt				Gaithersbur			Montgo	mery
Funeral Director			6. Sex	7. Age (In yrs. I		If Under 1 Yea Months Days				Y) 9. Birthplace (State or Forwalsh D.C.
Director		579-72-2285 Usual Residence of Decedent	1 M 2 F	52	Yrs		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Jan.	10, 177	4 Fortingsh. D.C.
any		10a. State 10b. County		1 1	, Town or Locati			_		10d Inside City Limits
land f show	for		gomery	Gai	thersbu					1 X Yes 2 No
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 728 Clopper Roa	ad Apt. #2	21		10f. Zip Code 20878			10g. Citizen of W United	,
r with t ms 23a		11. Marital Status		cedent Ever in U		S Decedent of His				e - American Indian, Black,
er death , or ite	Funeral	1 X Never Married 2 Ma	1 Yes	2 X No		es, specify Cuban		rto Rican, etc.)	Afri	<sup>te, etc.</sup> can American
21215-0036 Mental Hygiers after marked other than "natural", c event, the Medical Examiner	d by	3 Widowed 4 Divo	or Dates: or Dates:			Yes 2X No t's Usual Occupat		of work done	Specify:	usiness/Industry
6 72 hoi nn "na ral Ex	lete	Elementary/Secondary (0-12)	College (1		during mo	ost of working life.	DO NOT use r	etired)		
5-0036 led within 7 Hygiene. other than	Completed	17. Father's Name (First, Middle, I	4		Dining	Attenda		To de la la la la la la la la la la la la la		aurant
215- oe filed stal Hy ked of	Be C	Kenneth F. Hud	,					ide M. C	, Maiden Surname พ <b>าร</b> า	e)
221 hould the and Mer is man	2	19a Informant's Name/Relationsh			1		et and Number o	r Rural Route N	umber, City or Tow	vn, State, Zip Code)
- p = e =		Kenneth F. Huft	(father	•	6040	Sargent Ition (Name of cer	Rd. #41	08, Hya	ttsville	, MD 20782
9 2 2 2 is a		1 Burial 2 X Cremation		om State	crematory or oth	ner place)				
Baltimo permit. Page Department of Important:	1	4 Donation 5 Other Spe 21 Signature of Funeral Service L		1011		e Cremat		/27/06	neral Se	ille, MD
B Depri	y 3	Uncho Th	ampson		740	00 Georg	ia Ave.	N.W.,	Wash. D.	C. 20012
Physician /Medical	25 11	23a. Part I. Enter the disease, or of failure. List only one cause of	on each line.				such as cardiac	or respiratory a	rrest, shock, or he	Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Atheroscler	otic Cardiov		∍ase				Death
- man		Sequentially list conditions,	b							
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a	consequence o	νf):					
cecuted n and - transit	edical Examiner	events resulting in death) Last	Due to (or as a	consequence o	ıf):					
0, be executed sician and burial - transi	dica	UNPENDED	AMENDED							
		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, o	outcome of pregi		al death 3	Ectopic preg	nancy	23d. Date of Month	f delivery  Day  Year
X = 0 = 1	Physician/M	past 12 months?  1 Yes 2 No 9 V Unkr	4 Pregna	ant at time of de	ooth -	ner (Specify)	propio progr	ridirey	INOTAL	Day real
D. Be the de by the	Phy	Part II. Other significant condition	9 OHKHO		esulting in the u	nderlying cause g	iven in Part I	23e. Did	tobacco use contr	ibute to the cause of death?
<b>Records, P.O. Box</b> The law requires that the death cate has been signed by the atterpage 2 should be detached for 1	q p								es 2 <b>V</b> No 3	
ords v requi s been should	lete							24a Was		Were autopsy findings available prior to completion of cause of
Division of Vital Records, P.O. Bo. Is an or Attending Physician: The law requires that the deal is all Director: After this certificate has been signed by the attending the funeral director, page 2 should be detached for	Completed							perf	ormed?	death?  ✓ Yes 2 No
ician:	Be.	25. Was case referred to medical examiner?	Hospital: 4		ED/O		of Death (Chec			
n of V ding Phys 1. After thi funeral di	1.7	1 Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatient 28b. Time of In		y at Work?	28d. Describe	Residence 6 how injury occurr	
ion (eath.	ation	1 Natural 5 Pendir 2 Accident Invest		Day,Year)		1 Y	res 2 No		, ,	
ivisi lor At after d Direct d in by	Certification:	3 Suicide 6 Could	not be 28e. Place	of Injury - At ho	ome, farm, street	t, factory, office bu	uilding, etc.	28f. Location or Town,		er or Rural Route Number, City
ospital hours uneral ly filler		4 Homicide determ	(Opeciny)					2		<del></del>
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	Medical	(Check only   Certifying Phy	ysician: To the best niner:On the basis of and manner sta	of examination ar						
E 3 E 8	β	29b Signature and title of certifier	und mariner str	dieu.		29c. License	a number		29d. Date sign	ed (Month, Day, Year)
3		Monjone J	me Une	M		O.C.N	И.Е.		November	18, 2006
	- 1	<ol> <li>Name and address of person w Margarita Korell MD.</li> </ol>	who completed cause Assistant Med			enn Street, Ba	altimore. MC	21201		
St	ate	31. Date filed (May Cay, Xear)	2006 <sup>32</sup> ex	gistrar's Signatu	re /	16.3			-	

DHMH 17 Rev 1/2001

ORIGINAL

			Please Type or Print in Black Ir State of Maryland / Dep		-	•	
		•	- For	rtificate of Death		3. NP. N. N. S.	39621
i	Physici		1. Decedent's Name (First, Middle, Last)  Kathryn Margaret Heacock		2. Date of Death Month November	Day Year r 25, 2006	3. Time of Death 12:45 <sup>P M</sup>
	/Medic Examir	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	The second		Arcola Health & Rehab. Center	Silver Spring  If Under 1 Year If Under 24 Hrs.	0.0-1(0)-1	Montgomer	
н	Funeral		5. Social Security Number 6. Sex 1 M 2 F F	Months Days Hours Min.	8. Date of Birth (Month, Day, )		nplace (State or Foreign untry)
<u> </u>	Director		136-12-5590 94  Usual Residence of Decedent		April 9,	1912   New	York
	how how		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	e Ma 8a-f s	Director	Colorado Fremont Co	topaki			1 Yes 2 No
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show nnt, <u>the Medical Examlner must be notified at</u>	Dire	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cou	untry?
	eath v	Funeral	988 15th Trail         11. Marital Status         12. Was Decedent Ever in U.S.         13	Was Decedent of Hispanic Origin? (S	necify Yes or No-	USA 14. Race - Amer	ican Indian.
	ter d	표	1 □ Never Married 2 □ Married 1 □ Yes 2 🔂 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White	e, etc.
Maryland 21215-0036	urs al al", or Exam	þ	3 ★Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🙀 No Specify:		Specify <b>Whit</b>	e
5	n 72 hours "natural", edical Exa	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	king 10	6b. Kind of Business/I	ndustry
21	be filed within 72 ho ttal Hygiene. ed other than "natur event, <u>the Medical.</u>	du	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
2	Hygie Hygie Iher th	ပိ	12 Cle	rical Worker  18. Mother's Nan	ne (First, Middle, Ma		word_Compan
and	0 = 0 %	o Be	Herman Gustav Kirn			n Valkenbu	ra
Ž	2 should be filed with and Mental Hygiene, is marked other than raumatic event, the N	2		ing Address (Street and Number or Ru			
	nd 2 alth al 27 is 27 is ir trau		Richard F. Heacock/ Son 988	15th Trail, Cotop	aki, Colo	rado 81223	
ē,	ss 1 a of Hea item		20a. Method of Disposition 20b. Place of Disposition cemetery, cr	osition (Name of ematory or other place)		0c. Location - City or	Town, State
Ë	Page nent c int: If			an Chamatauri INOVE	ember 27, 2006 A	lexandria,	Virginia
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service Licensee	2 Name and Address of Facility Fancis J. Collins	Funeral	Home Inc.	
- 80	20 E 20 0			00 University Blv			
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
100	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Chronic Renal Fa	ilure			
	Examiner		Due to (or as a consequence of):  Hypertension				
8	8	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	cuted id ansit	Examiner	that initiated events C.				
60,	be executed ician and burial-transit		resulting in death) Last Due to (or as a consequence of):				
6876		dical	d				
9 ×	TO M	Completed by Physician/Medic	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of deli	ven.
Bo	atten for us	cian	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		Month	Day Year
o.	the d by the ached	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown				
Division or Vital Records, P.O. Box	w requires that the debeen signed by the should be detached	y P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ğ	equire en sig ould b	ed b	Alzheimer's Disease, Urinary Tract	Infection	1 ☐ Yes	3 2 <b>x</b> No 3 □ Pro	bably 4 □Unknown
မင္ပ	law re as be 2 sho	plet			24a. Was an autopsy	prior to c	topsy findings available completion of cause of
<u>=</u>	The ate h	Som			perform 1□ Yes 2	ed? death? Lydo 1 ☐ Yes	2 □ No
/ita	nding Physician: The law th. : After this centificate has be funeral director, page 2 s	Be	25. Was case referred to medical examiner?  Hospital: Hospital: 4   Description 2   DER/Outseting 2   DER/Outseting 3	Othor	ath (Check only one)	)	
ō	Phys this al dir	2	1 ☐ Yes 2 ☑ No ☐ 10 ☐ Inpatient 2 ☐ ER/Outpatie  27. Manner of Death 28a. Date of Injury 28b. Time	ATX INDISING F	fome 5 ☐ Residen	nce 6 Other (Spec	cify)
U	ding h. After funer	tion	1 ☑ Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	of 28c. Injury at Work?  M 1 Yes 2 No	20d. Describe nov	virgary occurred	
/isi	Atten deat ector:	fica	3 Suicide 6 Could not be 28e. Place of injury - At home, farm, s	treet, factory, office	28f. Location (Stre	eet and Number or Ru	ral Route Number,
ō	al or saffer	Certification: To	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Phwitin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical (	29a. Certifier (Check only one)  WEXCertifying Physician: To the best of my knowledge, deal control of the best of the best of my knowledge, deal control of the best of my knowledge, deal control of the best of				
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month	
	(0		Typue ( Q) Se	D34472	I	November 2	7, 2006
	W		30. Name and address of person who completed cause of death (Item 2(a) (Type Lynne Diggs, M.D. 10400 Connectic	Print) dt Avenue, #206, 1	Kensington	n, MD 2089	5
	Sta Regist	ate rar	31. Date filed (Menth-Day, Year) 2 8 2006 Angistrar's Signature	uli			
				· <del></del>			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryla				1ental Hy	giene		
		-	For State Registrar	Cei	rtificate of l	Death	+	Reg. No. 2	006	39622
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Carl F. Howell				2. Date of De Month Novembe	Day	Year	3. Time of Death 6:16 P M
(6) (6)	/Medic	_	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	hovembe		ty of Death	0:10 P
1	Examin	er	Washington Co. Hospital		Hagersto	own		Was	shingt	on
	Funeral			s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	9 Birthr	place (State or Foreign
	Director		034–30–6725 ¥□ M 2□ F 65	Yrs.			April 3		Salem, Massac	husetts
	and w		Usual Residence of Decedent           10a. State         10b. County         10c. 0	City, Town or Lo	cation			-		10d. Inside City Limits
	Aaryle f sho ed at	ō	New York Montgomery	Fort P	lain					1 ∐Yes XXNo
	the 28a-	Director	10e. Street and Number		10f. Zip Code			10g. Citizen o	f What Cou	ntry?
	h with	a Di	324 State Route 80		13339			USA		
9	thin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show Medical Examiner must be notified at	/ Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married  1 ☐ Never Married 2 ☑ Married  12. Was Decedent Ever in Armed Forces?  12. Was Decedent Ever in Armed Forces?  13. ☐ Yes 2 ☐ No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	Ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	В	ace - Americ lack, White, cify: <b>Whit</b>	etc.
2-0036	hours turat";	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education	16a. Dece	dent's Usual Occup	ation		16b. Kind of		
5	filed within 72 h Hygiene. other than "natuent, the Medica	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of work i)	king			
2121	d with giene rr than	mo:	12	Maint	enance			Manuf	actur	ing
	al Hyg	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam			ame)	
کاھا کا	ould be Mental arked o	To	William F. Howell	1		Rita	Nadea			
Maryland	s 1 and 2 should be filed wit if Health and Mental Hygiens Item 27 is marked other the other traumatic event, the		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address <i>(Street</i> State Ro	and Number or Ru nute 80.	ral Route Numb Fort	er, City or Ton Plain	n, State, Zij	w <sup>1</sup> 3339
	1 and Health em 27		Doris Howell (Wife)  20a. Method of Disposition 20b		osition (Name of matory or other place		Date	20c. Location		
JOL.	Pages nent of int: If Its iry or o				matory or other plac ark Ceme		/29/0	5 Ingh		Mills,
Baltimore,	permit. Pages Department of I Important: If Ite any Injury or o		21. Signature of Funeral Service Dicensee Oghstampf		2. Name and Addre	ss of Facility				York
ñ	Der any	i 10	Haw Machane Maco	1849 48	ochstamr 3 S. Chi	irch Sti	eet. 1	Vavnes	lnc. boro	, PA 17268
ľ			23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line	eath. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
V.	Physician		Immediate Cause (Final disease or condition	A. C	30000	D'isa an	2 <		1	Offset and Death
1	/Medical Examiner		resulting in death)  Due to (or as a cons	equence of):	2					75713
		er	Sequentially list conditions, b. Due to (or as a none							
Т	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
o,	an andrial-tra		resulting in death) Last  Due to (or as a cons	equence of):				-		
8760,	icate be executed physician and s the burial-transit	dical	d			-				
9		Med	IF FEMALE:	70.000						
Box	death certifii e attending p d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  4 □ regnant at time of	etal death 3[	☐Ectopic pregnanc	y			Date of deliv Month	Day Year
Ö	0 0	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	T douin of						
Division or Vital Records, P.	The law requires that the de ate has been signed by the a bage 2 should be detached f	by Pr	Part II. Other significant conditions contributing to death but not r	esulting in the u	inderlying cause giv	en in Part I.	23e. Did	tobacco use co	ontribute to t	the cause of death?
g	w require; been sig should by	ed b					1 🗆	Yes 2□ No	3 ☐ Pro	bably 4 □Unknown
900	e law re has bee	Completed					24a. Was	psy	prior to co	opsy findings available ompletion of cause of
Ť	The ate he page	Com					perf 1□ Yes	ormed? 2. No	death? 1 ☐ Yes	2 □ No
/ita	hysician: The Is his certificate has director, page 2	Be	25. Was case referred to medical examiner?  Hospital:		ot 3 DOA Oth	26. Place of Dea				
or	Physical this cal directly	P L	1 Yes 2 No 1 Inpatient 2 27. Vanner of Death 28a. Date of Injury		III JUDON	4 LI Nursing n	ome 5 ☐ Res	how injury occ		ffy)
O	ding Ph h. After th funeral	tion	Natural 5 ☐ Pending (Month, Day Year, 2 ☐ Accident investigation		Wor	rk? Yes 2∐No				
S	pital or Atteno burs after death eral Director: filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - Albuilding, etc. (Spe	t home, farm, st	reet, factory, office		28f. Location	(Street and Nu	mber or Rui	ral Route Number,
5	s afte al Dir	Cert	4 Tromode Building, etc. (ope			9	Only of Te	Wii, Giarcy		
	Hos Fun ely		29a. Certifier  1 Certifying Physician: To the best of my local Examiner: On the basis of exam							
	To the Hos within 24 hc To the Fun completely	Medical	one) and manner stated.  29b. Signature and title of certifier		29c. Licens	se number		29d. Date sig	ned (Month	, Day, Year)
	F≥Fŏ				Da	056165	-	L ]	L 2	5. 200%
			30. Name and address of person who completed cause of death (I	tem 23a) (Type,				10000		742
51	1-2+1		Steehen Katal mo 251	E. Ant	: + ~ 5	1. Hage	15+0-	am,	21	742
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signary 30 2006	gnature	A. H.	0				
	Regist	#: 1 m	MITTER TO THE TAXABLE	17.	LINELES					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Zainab Jetha 2006 November 22:10 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 21, 1991 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 💢 F Kigoma, Tanzania 85 Yrs. none Director Usual Residence of Decedent 10d Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show r than "natural", or Items 23s or 28s-f show the Medical Exercites must be notified at Maryland N. Bethesda Montgomery 1 ☐ Yes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20852 11341 Empire Lane Kenyan 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. e filed within 72 hours after if Hygiene. other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Asian Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife own home permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies Importent: If Item 27 is marked other tt
any injury or other traumatic event, Itea 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Labai Bandali JanMohammed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11341 Empire Lane N. Bethesda, Maryland 20852 a. Informant's Name/Relationship (Type, Print) Nizar Jetha -son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State George Washington Cemetery 11/26/2006 Adelphi, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, 4400 Powder MIII Road Beltsville; 21. Signature of Funeral Service Coensee Maryland 20705 Approximate Interval Between Onset and Death 23a. Part 1. Enter the asease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of) Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Jetha, Zainab 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No After this certificate has To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier za, MID 00057124 11/24/06 10. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Troung Bao, M.D. 9715 Medical Center Drive Rockville, Maryland 31. Date filed (Month, Day, Year) NOV 28 State 2006 Registrar

1123/06

			1 - Stete Amend #23a H	State of Ma Per Phy G86	nyland / Depa 2 12/27/0	artment of He tificate of D	ealth and Me Death	ental Hygie	ene 006	39624
			1. Decedent's Name (First, Middle, La	st)				2. Date of Death	Davi Va	3. Time of Death
	Physicia /Medic		Sandra Pauline	Jeter				Month Novembe	Day Year 21, 200	10:05 <sup>Рм</sup>
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or I	Location of Death		4c. County of Deat	
		7	Holy Cross Reha	b. & Nursi	ng Center	Burtonsv	ille		Montgome	ery
	Funeral		Social Security Number     6. S		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye		hplace (State or Foreign untry)
	Director		578-56-9397	□ M 2 RF	64 Yrs.	Michael Buys				ington, DC
	DQ .	}	Usual Residence of Decedent  10a. State 10b. County		100 City Town or La	ti				
	anyia ahov	_	Maryland Montgom	arv	10c. City, Town or Lo	r Spring				10d. Inside City Limits
	Ba-1	Director	- 3	CLY	51146					1 Yes 2 1
	vith ti		10e. Street and Number			10f. Zip Code		10g.	. Citizen of What Co	untry?
	s 23c	rai	10401 Conover			20902			USA	
	er de Itami	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spec n, Mexican, Puerto A	cify Yes or No- lican, etc.)	14. Race - Ame Black, White	
36	hours after death with the Maryland tural', or Itams 23a or 28a-1 ahow al Examinar must be notified at	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ ★ If Yes, Give Year or Dates:	0	1 ☐ Yes 2 ☑ No	Specify:		Specify:	Black
21215-0036	d within 72 hours after death with the Marylan jene. r than "natural", or Itams 23a or 28a-1 ahow tha Madical Examinar must be notified at		15. Decedent's Ed		16a Dece	dent's Usual Occupat	tion	161	b. Kind of Business/	
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	e filed of Hygie other twant, the	0	17. Father's Name (First, Middle, Last)		110		18. Mother's Name	(First, Middle, Mai		
Maryland	2 should be f and Mental I la marked or raumatic ava	To B	Emmett Belford J	eter			Carmel N	eale		
ary.	shound Mind Mind Mind Mind	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Street ar			ity or Town, State, 2	Tip Code)
	l and 2 lealth a lm 27 le har trai		Melba Y. Piersma	/ Sister		01 Conove				
ā,	s 1 and 2 should be filled if Health and Mental Hyg itam 27 ia marked othe othar traumatic avant,		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	Da	-	. Location - City or	
Baltimore,	age ent o ht: If		Magazial 2 Gremation 3 ⊆ '4 Donation 5 Other (Specif			matory or other place demorial C	No.	v. 28		
≣	nit. F artm orter injur	İ	21. Signature of Funeral Service Licer			2. Name and Address		2006 Su	itland, M	aryland
ä	permit. Pages 1 an Department of Heal Importent: If itam 2 any injury or other once.		1	2 solon	F	rancis J.	Collins	Funeral	Home Inc.	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cabeed	the death. Do not ent	00 Univer	such as cardiac or	respiratory arrest,	ver Sprin	Approximate
	Dhusisian		minediate Gause (Final	one cause on each line	• Advanced	l LeiomyoS	arcoma			Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a. Dup lo (or as a	consequence of):	ryecist (	CHACER			
	Examiner			Due 10 (01 as a	consequence on).					
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_	= D 6									
Вох	death certifi e attending id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Teteria - so			23d. Date of deli	very
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s, I	requires that the een signed by th hould be detache	by F	Part II. Other significent conditions of	ontributing to death bu	t not resulting in the u	nderlying cause giver	n in Part I.	23e. Did tobac	co use contribute lo	the cause of death?
D	w require been si should t							1 ☐ Yes	2 No 3 Pro	babiy 4 DUnknown
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æ	0 - 0	E						autopsy performed	1? death?	ompletion of cause of
Ita	certificate	Se C	25. Was case referred to medical				26. Place of Death		[40] 12 163	2,20110
of Vital Record	ys di o	To B	examiner? 1 ☐ Yes 2 🙀 No	Hospital: 1   Inpatier	nt 2 ER/Outpatier	Other			e 6 Other (Spec	ufv)
	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Injun		28c. Injury a Work?		3d. Describe how i		
<u>.</u>	Attanding ir death. actor: After by the fune	atic	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	1			es 2 🗆 No			
Division	or Attancatter death Diractor: in by the	ertification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, farm, str	eet, factory, office	28	3f. Location (Stree City or Town, S	t and Number or Ru	ral Route Number,
	rs aft	Cer		January, oto	. (0,000.))			only or rown, o	itale)	
	To the Hospital or Attandi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu		29a. Certifier 1 Certifying Ph	ysicien: To the best o	f my knowledge, deatl	occurred at the time	e, date and place, an	nd due to the caus	e(s) and manner as	stated.
	the hin 24 the F	ledical	0,10)	and manner stat	ed.			at the time, date	and place, and due	to the cause(s)
	To To COL	Σ	29b. Signature and tille of certifier	and a		29c. License			Date signed (Month	, Day, Year)
•	5					Dec 54	-566	(1)	126/06	
	ر		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print)				
			SUN i Fine Pine quit 31. Date filed (Month, Day, Yeal) NOV 28 20	ELLI, 1220	O AGAST	roppa fic	ad sun	4230 7	SWSON 1	41721286
	Sta		31. Date filed (Month, Day, Year)	32 Registra	r's Signature	all i	, , , ,	/		
	Registr	ar	NUV 20 2	PO PLAS	, St. Age	-64				

			For State	State	of Marylar	-	artment of F		l Mental H	ygiene/ Reg. No.	2006	39625
at A.			Registrar  1. Decedent's Name (First, Middle	e, Last)					2. Date of I	Death		3. Time of Death
	nysicia		Virginia May	Jones					Novemb	Day Der 28	Year 2006	7:00 A M
	Medic xamin	100	4a. Facility Name (If not institution		umber)		4b. City, Town, o	r Location of Dea			County of Death	1 7 7 7 22
	Aaiiiiii	C1	Ravenwood Lut	heran Vil	lage		Hagerst	own		W	ashingt	OD
Fu	neral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	if Under 1 Year Months Days		rs. 8. Date of E	Birth Day, Year)	9. Birth	nplace (State or Foreign intry)
	ector		214-36-0755	1□M 2X1F	91	Yrs.	World Bayo	Tiouro IVIII		2 1915		/land
pu .			Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or Lo	cation				T	10d. Inside City Limits
anyla	dat	-			100.01	•						1 Y Yes 2 □ No
he M	otifie	Director	Maryland Wash:	ington		Hager	stown 10f. Zip Code			10g Citiz	en of What Cou	intry?
with t	ben	ä						4.0				
eath	nust	Funeral	Luther Drive  11. Marital Status	12 Was De	cedent Ever in U	LS. 13.	Was Decedent of H	<del></del>	(Specify Yes or	US <sub>A</sub>	A 4. Race - Amer	ican Indian,
ter de	iner	F	1 Never Married 2 Mar	Armed F	Forces? 2 🔯 No Bive		If Yes, specify Cub	an, Mexican, Pu	erto Rican, etc.)		Black, White	e, etc.
urs af	xam	þ	3 Widowed 4 ☐ Divorced	If Yes, G Year or	aive Dates:		1 ☐ Yes 2 🖾 No	Specify:			Specify:	White
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should be filed within 72 hours after death with the Maryland and Mental Hyglene.	narke natic	은	Edward Ackerman			405 14-15	ng Address (Street	Elizal		inknowi		in Cada)
Manc hanc	traum		19a. Informant's Name/Relations				,					
T and Healt	ther		Glenn Jones - S	50n	20b.	Place of Dispo	A High Position (Name of	i	Date		eation - City or	
paritimore, interpretation 2 12 13-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.	0.0		N Burial 2 ☐ Cremation		n State	•	matory or other pla	1	11.100	77.		1 1
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perm Deps	any in		18000	20.0	•		15 E. Wi					
	الالا		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that	caused the dea						wiry rice	Approximate
Dhuo	inian	62 5	Immediate Cause (Final	t only one cause on	each line.	C-1740 - 1172	1.00		190 IV			Interval Between Onset and Death
	ícian dical		disease or condition resulting in death)	a. Due to	o (or as a conse		neterie	FHILL	say aus	wze	-	10 years.
Exar	niner				0-	Gnioi			O			2 weiks.
	- 10	je	Se wentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D. Due to	o (or as a conse	quence on.						
cuted	ransi	Examine	that initiated events	С								
Ords, P.O. BOX 00/00, requires that the death certificate be executed	physician and s the burial-transit	Ä	resulting in death) Last	Due to	o (or as a conse	quence of):						
ate be e	hysic the bi	dical		d					-			
	e as	Mec	IF FEMALE:	000 16.000								100
ath cer	or us	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	outcome pf pregrebinth 2 Fet	tal death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у		2	3d. Date of deli Month	very Day Year
_ e :	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unk	gnant at time of known	qeam ot	_ Other (specify) _			-		
that t	ed by detac		Part II. Other significant condit	ions contributing to	death but not re	sulting in the u	nderlying cause giv	ven in Part I.	23e. D	id tobacco us	se contribute to	the cause of death?
S E	sign d be	d by							1	Yes 2	□No 3 (XPr	obably 4 Unknown
ecords law requires	shou	ete							24a. W	as an	24b. Were au	topsy findings available
The law	certificate has been signed by the attending prector, page 2 should be detached for use as	Completed							– l au	itopsy erformed?	prior to death?	completion of cause of
VICALI	ificate or, pa	e Co	25. Was case referred to medical	al	-			26. Place of F	1 Ye Death (Check on		1 □ Yes	2. No
Or VITA Physician;	s cert direct	0 8	examiner? 1 ☐ Yes 2 █ <b>√</b> No	Hoepital:	Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	,	gHome 5□R		S □Other (Spec	cify)
VISION OF r Attending Phy er death.	er thi	Ë	27. Manner of Death	/6.4.	te of Injury onth, Day Year)	28b. Time o	of 28c. Inju			oe how injury		
ath in	ir. Aff	aţie	Z Accident	tigation		,,		Yes 2 □ No		_		
al or Attending F	recto	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deteri	mined   28e. Pla	ce of injury - At I Iding, etc. (Spec		reet, factory, office			n <i>(Street and</i> Town, State)		ıral Route Number,
ital o	ieral Director: After this certific filled in by the funeral director,	Ce										
108 108	들층	ca	(Check only 2 Medica	ing Physician: To t il Examiner: On the	basis of examin	nation and/or in	nvestigation, in my	opinion, death o	ccurred at the tir	ne, date and	place, and due	to the cause(s)
To the I	To the Fur completely	Medical	29b. Signature and title of certifi		anner stated.		29c. Licens	se number		29d. Date	e signed (Monti	h, Day, Year)
To	2 0		D. Orginature and title or certifi	9/	Fual	7	Dr	8365		/	1-28-1	6
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5H-	2		30. Name and address of pe so	n who completed ca	Afri.	368	29c. Licens D2 Print) St	Cred-	Heige	tonis	~ 190	2/140.
y 11	Sta	ate	31. Date filed (Month, Day, Yea,	2 2000 32	. Ragistrar's Sigi	nature	1		0-	, 0,000		
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			for State	State of Ma	aryland.	Department of I		Mental Hy	gien	9006	39626	
			1 - State Registrar			Certificate of	Death	2. Date of D	Reg. No	5. 0 0 0		_
П	Physici	an	1. Decedent's Name (First, Middle, Lasi	)	K	NIATT		Month	Da	Yeer Yeer	3. Time of Death	ł
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Deat	h	40	County of Deatl		
	Exami	iei		ospital		East	on		Talbot			
	Funeral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. last	birthday) If Under 1 Year		(Month, E	av. Year.	9. Birth	npface (State or Foreigr untry)	n
	Director		220-09-1349 15 Usual Residence of Decedent	ZM 2□F	86	Yrs.		October	21, 1	1920 Mar	yland	
	land ow		10a. State 10b. County		10c. City, T	own or Location					10d. Inside City Limits	
	Man Med sh	ţċ	Maryland Caroli	re		Denton					1 ☐ Yes 2 反 No	j.
	or 28	)ire	10e. Street and Number			10f. Zip Code			-	itizen of What Co	-	
	ath w	Funeral Director	22744 Shore Highw				629				s of Americ	cc
	ter de	-ine	11. Marital Status  1 ☐ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ 1		13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	specify Yes or N to Rican, etc.)	0-	14. Race - Amer Black, White		
920	urs aff	þ	3 ☐Widowed 4 ☐Divorced	If Yes, Give Year or Dates:	••	1☐ Yes 2 <sup>™</sup> No	Specify:			Specify: Ca.	ucasian	
Ģ	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or Itams 23a or 28e-f show event. The Medical Examinational by modified at	Completed	15. Decedent's Edi (Specify only highest grad	ucation	1	6a. Decedent's Usual Occu (Give kind of work done	pation during most of wo	rkina	16b. F	Kind of Business/I		_
2	ithin ne.	mple.	Elementary/Secondary (0-12)	Coflege (1-4or 5	5+}	life. DO NOT use retire	d)	9			_	
2	filed withi Hygiene. other ther	S	11 HS Grad 17. Father's Name (First, Middle, Last)			District Ma	18. Mother's Na	me (First Middl	••	lectric (	Company	
au	be od o	To Be	Nicholas	Eugene Kno	ott			ce Lill				
Maryland 21215-0036	should be and Mental Is marked of aumatic ev	F	19a. Informant's Name/Relationship (7)			9b. Mailing Address (Street					"ip Code)	_
	and 2 s lealth ar m 27 ls her trau		Elizabeth P. Knot	t Wife		22744 Shore H		Denton,	Mary	yland 21	629	
altimore,	- I 0 =		20a. Method of Disposition 1	Removal from State	20b. Plac	e of Disposition (Name of etery, crematory or other pla		Date		ocation - City or		
Ē	Pages tment of I tant: If it		*4 ☐ Donation 5 ☐ Other (Specify	)	Den	ton Cemetery				ton, Mar		
Ba	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licens	1000		22. Name and Addre Moone Fune 12 South S	ess of Facility ral Home,	, P.A.				
			23a. Part1. Enter the disease, or comp	lications that caused	the death. I	Do not enter the mode of dyi	<u>econd Sモ</u> ng, such as cardia	<i>cet, Di</i> correspiratory	<u>2NTO/</u> arrest,	r, Maryl	Approximate	
J.	Physician		shock, or heart failure. List only of Immediate Cause (Final	one A se on each li	. M	vocardia	IZNI	FARA	Tro	M A	Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequen	e of):	7	1316	110		reore	
	Examiner	L	Sequentially list conditions,	.COM	nan	y tree	RY 1	rise	28	2	nvone	
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a cons uen	e of):	/					
	be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as	a consequen	ce of):						
760	death certificate be executed e attending physician and id for use as the burial-transii	<u>6</u>		d								
687	leath certificate b attending physic I for use as the b	Physician/Medic	IE ECHALC.									
Box	th certendir	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetaf de	ath 3 Ectopic pregnance	у			23d. Date of deli	v <i>e</i> ry Day Year	
0	the at	/slci	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death	n 5 ☐ Other (specify) _				MONIT	Day	
<u>.</u>	The law requires that the de ite has been signed by the bage 2 should be detached		Part II. Other significant conditions co	ntributing to death b	ut not resultir	g in the underlying cause gr	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?	
ds,	uires sign	Completed by	CONGESTIVE	= HEA	RI	PAILUR	-	1 🗆	Yes 2	No 3□Pro	obably 4 Unknown	
Record	s beer shou	lete						24a. Wa		24b. Were au	topsy findings available completion of cause of	3
	The lav	шо						aute per 1 ☐ Yes	opsy formed? 2 land	death?	completion of cause of	
Viital		BeC	25. Was case referred to medical examiner?				26. Pface of De			7		
	ys S	10	1€Yes 2□No	Hospital:		Culpatient 3 DOA	ner: 4 ☐ Nursing H	dome 5 ☐ Res	idence	6 ☐Other (Spec	:ify)	
o u	ing P	on:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry Year) 28	b. Time of 28c. injury Wo	rk?	28d. Describe	how inju	iry occurred		
Sic	or Attanding Phater death. Diractor: After the in by the funeral	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of Ini	ury - At home	M 1 [	]Yes 2□No	28f Location	(Street a	nd Number or Ru	rai Route Number.	_
Division of	after Dirac	ertif	4 Homicide determined	building, et	c. (Specify)	, iam, shoot, factory, office		City or To			ar riodio riambor,	
	To the Hospital or Attanding within 24 hours after death.  To tha Funerel Diractor: After completely filled in by the fune.	alc				dge, death occurred at the ti						
	he Ho in 24 I ha Fu pletel	edical	(Check only 2 Medicel Exam	and manner sta		and/or investigation, in my	opinion, death occu	urred at the time	, date an	d place, and due	to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signalure and title of certifier	() DALLON	/mx	Denty 29c. Licen	se number		29d. Da	ate signed (Month	Day, Year)	
			CHANKELLE E	Yeuru	1111	NIE	1004		NO	v 04	1006	
			30. Name and address of perso o	pleted cause of	087	670 De	500W /	MD 2	16	29		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	100		- 4		V · 1		
	Regist			1		4						

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Registrar

31. Date filed (Mont

MEMORTAL

32. gistrar's Signature

2 9 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** November 26, 2006 3:55 AMKyber Frederick Oscar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital 9. Birthplace (State or Foreign Country) 1923 New Jersey If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year March 28, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Year) 1 MM 2 F 83 579-09-3554 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or Items 23a or 28a-f show Items adical Examiner must be notified at 1 ☐ Yes Ž ☐ No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 USA 3944 Wendy Lane Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Ite any injury or other traumatic event, the Medical Examines 1**★** Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married SpecifWhite 1 ☐ Yes 21 No Specify þ 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Cryptologist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Katherina Schnurr Max Kyber မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3944 Wendy Lane, Silver Spring, MD 20906 Ann Joachim Kyber/ Wife Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 30, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 2006 Silver Spring, Maryland 21. Signature of Funeral Service Licenses Francis Agdress Collins Funeral Home Inc. Silver Spring, MD 20901 500 University Blvd, W, Campo Approximate Interval Between Onset and Death 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Severe Sepsis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) physician Be Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy detached for in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown should be Certification: To

Division or Vital Records. P.O. Box 68760. or Attending Physician: after death

Baltimore, Maryland 21215-0036

filled in by the funeral

Medical

State

Registrar

within 24 hours a

To the Funeral I

completely filled To the

Part II. Other significant conditions of Acute Renal Insu	•	sulting in the underlying yperkalemia			se contribute to the cause of death? Mo 3 □ Probably 4 □Unknown
Volume Depletion	1			24a. Was an autopsy performed? 1  Yes 2  No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1X Inpatient 2	ER/Outpatient 3□ I	DOA Other: 4 Nursing	Home 5 ☐ Residence 6	Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred .
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, street, factify)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
	nysician: To the best of my known iner: On the basis of examinating and manner stated.				and manner as stated. place, and due to the cause(s)

29c. License number

D63579

29d. Date signed (Month, Day, Year)

November 26, 2006

Maria Tayag, M.D. 31. Date filed (Month, Day, Year)

NOV

29b. Signature and title of

Registrar's Signature

1500 Forest Glen Road, Silver Spring, MD 20910 2006 28

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Edyth KUSIK 16, 2006ª 9:50 A. November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Potomac Manor Care Potomac 8. Date of Birth (Month, Day, Trine 5, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. New York Director 90 085-01-0759 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notifled at Chevy Chase **Funeral Director** MD Montgomery 1 □Yes 2√ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8100 Connecticut Ave. #724 20815 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo White Specify: <u>م</u> 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Knittle Anna Julius Wald 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7401 Masters Drive, Potomac, MD 20854 Elaine Henry, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If It any injury or c once. Hungarian Union Field Cem. 19, 2006 1 

Burial 2 □ Cremation 3 □Removal from State Queens, NY 4 Donation 5 Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home, Inc 21. Signature of Funeral Service Lice 254 Carroll St., N.W., Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Advanced Physician Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be execute the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signe page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1□ Yes 2√E No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2X No 1 🔲 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred (Month, Day 1 X Natural 5 Pending investigation 1 Tes death after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide To the Hospital hin 24 hours a the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054566 Nov. 17, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli, MD 1220 A East Joppa Road, Suite 230, Towson, MD 21286 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 28 2006 Registrar

				artment of Health and Me	ntal Hygie	_	39630	
			Decedent's Name (First, Middle, Last)		Date of Death	3	3. Time of Death	
	Physicia		Doris Virginia Larrimore	N		Day Year	3:35 p M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	, оз р	
		•	22026 Gannon Drive	Preston	(	Caroline		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.   8	Date of Birth (Month, Day, Ye	9. Birtholace	e (State or Foreign	
	Director		213-24-1413 <sup>1 M 2</sup> F 79 Yrs.		ug. 18,	1927 Pennsy	lvania	
	D		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	- cotion				
	sho!	5		lock			Inside City Limits 1 ☐ Yes 2/☐√No	
	Ne M	ect	10e. Street and Number		T			
	with a or	급	6601 Cabin Creek Court	10f. Zip Code		Citizen of What Country		
	na 23	Funeral Director		Was Decedent of Hispanic Origin? /Specif		1ited Stat		
_	fter d	Fun	Armed Forces?  1 Never Married 2 Married 1 Yes 3/12/No	Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Richard Control of C	an, etc.)	Black, White, etc.		
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7	gien grith	8	12 Rest	aurant Owner	Re	staurant		
/land	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or Itama 23e or 28e-f show aumatic event, the Madical Exacultar marked the rediffed at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (F		den Sumame)		
<u>X</u>	Men Men arke	၉	Victor George Pepper	Alma Jean				
Jar	2 sh and is m	5 57		ing Address (Street and Number or Rural F				
e,	and lealth m 27 har t	- 1	Woodrow Larrimore/Son 220	26 Gannon Drive,				
0	t of H if ite or ot		Tuy burial 2    Cremation 3    Hemoval from State	matory or other place)		. Location - City or Town,		
	Pe tmen tant:		4 Donation 5 Other (Specify) Hill Cre	est Cemetery 11/30	/06 Fe	ederalsbur	g, MD	
Baitimor	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiens. Department of Health and Mental Hygiens. Important: if Item 27 is marked other than "natural", or itama 28a or 28a-f show eny injury or other traumatic event, the Marical Exacilinar traint be notified at once.		21. Signature of Funeral Service Licensee  Thinkled T. Estow  2	Name and Address of Facility Framp 16 N. Main St., Fed	tom Fune	ral Home, P	.A.	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Ac	oproximate terval Between	
i	Physician		Immediate Cause (Final				nset and Death	
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):					
	Examiner		Securetially list conditions					
-	p =	ner	Sequentially list conditions, if any, leading to immediate ause. Enter Underlying Cause (Disease or injury					
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8/00,	icate be executed physicien and the burial-transit	dical	d					
0 X	ding p	Me	IF FEMALE: 23c. If yes, outcome of pregnancy				-	
X00	The law requires thet the death certifies the second ing see has been signed by the attending pege 2 should be detached for use as	Physician/Me	in the past 12 months?	Ectopic pregnancy		23d. Date of delivery  Month Da	y Year	
j	the de	yslc	1 ☐ Yes 2 Storo 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)				
ŗ.	thet the detail		Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to the c	ause of death?	
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Š	v req	Completed			04-145	00.14		
ě	has ge 2	E P			24a. Was an autopsy performed	24b. Were autopsy prior to comple death?	etion of cause of	
	sician: The law certificete has b irector, pege 2 s		OF Western Management of the Control		1□ Yes 2		] No	
=	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 2500 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outnatie	26. Place of Death (	^			
	Phy r this aral d	$\vdash$	27. Manner of Death 28a. Date of Injury 28b. Time of	TIL SLI DOA 4 LI Nursing Home	5 Describe how in	e 6 □Other (Specify)		
JIVISION	Attending it death. ector: After by the fune	Į.	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	of 28c Injury at 28c Work?  M 1 ☐ Yes 2 ☐ No		.,,		
2	Atter dea octor y the	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, si		Location (Street	t and Number or Rural Ro	oute Number	
5	al or	Certification:	4 Homicide Cetermined building, etc. (Specify)	,	City or Town, St			
	papita hours inere		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, and	d due to the cause	e(s) and manner as state	d.	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his complately filled in by the funeral director, page	edicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred	at the time, date	and place, and due to the	e cause(s)	
	To to to to to to to to to to to to to to	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day		
			WP	D00539 25	11 6	128/200	6	
			30. Name and address of person who completed cause of death (Item 23a) (Type	. Print)				
			31. Date filed (Month, Day, Year) NOV 2 8 2006  32. Registrar's Signature	n Ave Preston	WD	21655	i i	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Set of				
	Registr	ar	NUV & C ZUUb					

		•	For State Registrant 120er FH11/3	State of Maryland	d / Depa <i>Cer</i>	artment of H tificate of	lealth a <i>Death</i>			Reg. No.	006		
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Luckritz				l 2	t. Date of Dea Novembe	ath ⊇r 27.	2Ŏ <del>0</del> 6	3. Time of Dea 1:45A.	ath M
	/Medic Examin		4a. Facility Name (If not institution, give str Laurel Regional H	reet and number)		4b. City, Town, o	or Location of			4c. Co	unty of Death	George's	3
	Funeral Director		377 40 3402 A	7. Age (In yrs. It		If Under 1 Year Months Days	If Under 2 Hours	Min. E	Date of Birt (Month, Da )ec.12	, 1929	9. Birth Cou IoW	nplace (State or Fountry)	reign
	Maryland -f ehow iled et	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland Prince Geo		Town or Lo							10d. Inside City Li 1 ☐ Yes 2	
	death with the Maryland me 23a or 28a-f ehow r mass be profitted at	al Directo	10e. Street and Number 4307 Briggs Chaney	Road		10f. Zip Code 207	05				of What Col		
	be filed within 72 hours after death with the Marylan Hygiene. d other then "natural", or iteme 23a or 28a-f show event, the Medical Examinar must be publified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed Ampivorced	2. Was Decedent Ever in U.S Armed Forces 1 Tyes 2 1 1 Yes. Give Year or Dates 1950 - 1		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 ☑ No		jin? (Speci , Puerto Ri	fy Yes or No can, etc.)		Race - Amer Black, White ecify:		
	d within 72 ho piene. r then "natur ine Medical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0,12)	ation	16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retire	oation during most d)	of working	7	16b. Kind	of Business/I	ndustry	
Maryland		To Be C	17. Father's Name (First, Middle, Last) Herman Luckritz					r's Name ( n Hil	First, Middle, Lbert	Maiden Su	mame)		
	and 2 sho seith and N n 27 is ma		19a. Informant's Name/Relationship (Type Debbie J. Perhach -		1	ng Address (Street avol Roa							
Baltimore,	nit. Pages 1 and 2 should artment of Heelth and Mer ortant: If Item 27 le marks Injury or other traumatic		20a. Method of Disposition  1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		emetery cres	esition (Name of matory or other pla tan Crem	atory	Da 11/27			andria	rown, State , Virgini	la
Balti	Departic Departic Imports any inju		21. Signature of Piner (Service License	Hanks	B	omaldove 400 Powd	°°Bofgw er Mil	ardt 1 Roa	Funerad Bel	al Hon tsvill	ne, PA Le, Man	cyland 20	
4	Physician		23a. Part 1. Enter the disease, or complic shock, or hear failure. List only one Immediate Cause (Final disease or condition	ations that caused the dealth cause on each line.  Arteriosc.						rrest,		Approximate Interval Betwee Onset and Dear	
	/Medical Examiner		resulting in death)  Sequentially list conditions.	Due to (or as a consequence Hypertens:	ion								
,09/	ate be executed sysicien and he burial transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)									
P.O. Box 68	ath certifica ittending pt or use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ □ Unknown	ic. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of do	death 3	□Ectopic pregnand □ Other (specify) _	ey .			230	d. Date of deli Month	ivery Day Yea	r
	quires that the de n signed by the a uld be detached f	٥	Part II. Other significant conditions conf	ributing to death but not resi	ulting in the u	nderlying cause gi	ven in Part I.	-patrice		obacco use Yes 2 1		the cause of death	
Division of Vital Records,	The law require sete has been sin page 2 should to	Completed								an posy primed?	death?	topsy findings ava completion of caus 2 \( \subseteq \text{No} \)	ilable e of
Zita Zita	ysicien: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 🛣	EB/Outpation	-1 2 DOA   O:	har		(Check only		Other (Spec	nif.)	
ion of	ding Ph h. After th funeral	ation: To	Yes 2	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Inju	4 🗀 140	28	d. Describe			any)	
Divis	el or Attendes s after deatl il Director: ed in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, st	reet, factory, office		28	Bf. Location ( City or To	Street and I wn, State)	Number or Ru	iral Route Number	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical (		ician: To the best of my kno er: On the basis of examina and manner stated.									
•		Me	29b. Signature and title of certifier	AR -	4	.	024721					h, Day, Year)	
	10		30. Name and address of person who cou	mply ed cause of death (Item	23a) (Type	Print)						27, 2006	
	C+	ate	Syed Sadiq, M.D. 14				Laure	e⊥, Ma	aryıan	20/0	<i></i>		
·ė	Regist		NOV 28 200		A DE	West of							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39632 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Marvin Lewis Ε. November 23, 2006 8:10 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4710 Ravenswood Drive <u>Riverdale</u> Prince George's If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 51 Yrs. 8. Date of Birth July 8, 1955 Social Security Number 6. Sex Birthplace (State or Foreign **Funeral** Months Days Hours 296-52-1419 Ohfo<sup>intry)</sup> Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at Maryland Prince George's Riverdale 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20737 4710 Ravenswood Drive United States Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Arged Forces? 1 [2]Yes 2 □ No If Yes, Give 1972–1973 Year or Dates:1972–1973 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Black δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry District of Columbia College (1-4or 5+) 1-4 Elementary/Secondary (0-12) Government permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important; If item 27 is marked other that any injury or other traumatic event, the gnee. Social Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Barbara Jean Lewis unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4710 Ravenswood Drive Riverdale, Maryland 20737 19a. Informant's Name/Relationship (Type. Print)
Susan M. Lewis -wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 11/26/2006 Alexandria, Virginia 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signatur Fundal Siville Licence 22. Nam**Donate** V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, MD2070 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** tepul: Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 3 ☐ Suicide 6 Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

3+1

Registrar's Signature 31. Date filed (Month, Day, Year) 28 2006 NOV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fryleside Office Park Alexandrin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day November 24, 2006 a N 8:10 John Anthony Matiukas, Sr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Holy Cross Hospital Silver Spring Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 □MM 2 □ F Yrs May 25, Lithuania 86 579-42-8139 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes X□No Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20902 Lithuania 1735 Dublin Drive 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 2X No Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ENO Specify. SpecifWhite 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction 12 Pipe Layer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Alfonzo Matiukas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 207 Bishops Glen Drive, Frederick, MD 21702 Edward A. Matiukas/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 27, 1 → Burial 2 Cremation 3 Removal from State Nov. Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Silver Spring, Maryland 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Smes Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) a Metastatic Squamous Cell Cancer of Lip Due to (or as a consequence of): Cachexia of Malignancy Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2 1No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 IDOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending

**Physician** /Medical **Examiner** Examiner

physician and s the burial-trans

attending p as

signed by t

page 2 s

certificate

tal or Attending Physician: Tis after death.
al Director: After this certificate ed in by the funeral director, pa

To the Hospital o within 24 hours aff To the Funeral D

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Physician/Medical

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Completed

Be

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Certification:

Medical

requires that the death certificate be executed

Box 68760.

P.0.

Division or Vital Records,

**Physician** 

Examiner

**Funeral** 

Director

'natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be n

3altimore, Maryland 21215-0036

be notified at

Director

Completed by Funeral

Be

ဂ

the Maryland

/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

2 Accident

3 ☐ Suicide

one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of

investigation

6 Could not be determined

29c. License number BK9758876

November 24, 2006

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raina Kapoor,

1500 Forest Glen Road, Silver Spring, MD 20910 M.D.

State Registrar

completely filled in by

31. Date filed (Month, Day, Year) VON 28



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

		1	For State Registrar	State o	f Marylan	-	artment o			ental Hygi	ene	106	39634
		_	I. Decedent's Name (First, Middle, La.	it)	-					2. Date of Death Month		Year	3. Time of Death
Phys /Me	sicia: edica	_	Mary Elizabeth Mo	ore					N	November	27,	2006	12:15 A <sup>M</sup>
	mine	r 4	a. Facility Name (If not institution, give					m, or Location				inty of Death	
			Williamsport Nurs		1e 7. Age (In yrs.	last hirthday)	If Under 1 Y	amsport	er 24 Hrs.	8. Date of Birth		ingto	II aplace (State or Foreign
Fune: Direct			217-80-0722	_M 2jX(F	87. Age ( <i>iii y</i> 13.			ays Hours	Min.	Month, Day, Oct 29,	Year) 1919	Mary	untry)
			Jsual Residence of Decedent										101 Luide Obelieibe
ırylan	١.		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits 1   Yes 2 □ No
Ba-f		000	Maryland Washingt	on	Hag	gerstov	n 10f. Zip Co			10	On Citizon	of What Co	70
with ti	1 2	בוב	10e, Street and Number 10903 Coffman Ave				2174			1	.S.A.		orti y :
leath		e .	11. Marital Status		edent Ever in U	.S. 13.			origin? (Spe	cify Yes or No- Rican, etc.)	14.	Race - Ame	
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yidilia K I K I S-0000 ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other then "nature!", or Items 23a or 28a-f show ails event the Medical Examinar must be notified at	ſ	S P	17. Father's Name (First, Middle, Last					18. Mot	her's Name	(First, Middle, N	faiden Sur	name)	
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ages nt of th			1≱Burial 2 ☐ Cremation 3 ☐	Removal from	State		matory or other		12/1/2				Maryland
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/Medio			resulting in death)		(or as a consec	quence of):							
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that the death certificated by the ettending ph	3	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1☐Live	birth 2 Feta nant at time of a	aldeath 3	☐Ectopic pregr ☐ Other (special				230	Date of del Month	Day Year
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DIVISIO Il or Attendi efter deeth. Director: A	in h	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	200. Plac	e of Injury - At h	nome, farm, si	reet, factory, o	ffice	1	28f. Location (St City or Town		umber or Ru	ural Route Number,
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To the Hospital or A within 24 hours effer	completely filled in by	Medicai	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	miner: On the	ie best of my kn basis of examin nner stated.	iowledge, dea ation and/or i	th occurred at the occurred at	the time, date my opinion, o	and place, a death occurr	and due to the cared at the time, d	ause(s) an ate and pla	d manner as ice, and due	s stated. to the cause(s)
othe ithin 2 othe	e du	Med	29b. Signature and title of certifier	and ma	miler stated.		29c. L	icense numbe	er er	2	9d. Date s	igned (Mont	h, Day, Year)
- 3 - 1	8		1E House	(VU)			D	5370	0	1	JOHER	WIZEIZ	28, 2006
		ļ	30. Name and address of person who	completed cau	use of death (Ite	m 23a) (Type					J-01	V/ O V	
			TED E. HOW	E. M	11	<u> </u>	1515SY	YN S	ot, u	الإالها	v590	RT,	erys.
Da	Stat		31. Date filed (Month, Day, Year)	1	Registrar's Sign	nature	, .						
Re	gistra	या	NOV 30	2006	Mary	Ra .	Johnson			-			

DHMH 17 Rev 1/2001

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Harry Edgar Myers Jr. 24 2006 November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Washington County Hospital Hagerstown Year If Under 24 Hrs 7. Age (In yrs. last birthday) If Under 1 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Days **Funeral** Months 1**X**XM 2□ F 174-20-8725 Usual Residence of Decedent May 22 1928 Director Pennsylvania 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 No ed other than "natural", or items 23a or 28a-f sh event, the Medical Examiner must be notiffied Director Maugansville Washington Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number U.S.A. items 23a 21767 17821 Blue Bell Drive by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. M∏ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene. nt: If item 27 ls marked other than "nat Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Truck Mfg. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Anna Peters Harry E. Myers ၉ traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) f Health a <u> 17821 Blue Bell Drive Maugansville Maryland 21767</u> <u>Helen L. Myers (wife)</u> other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11-26-2006 Smithsburg Maryland 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 Ulucho. 23a. Part1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or here dailure. List only one cause of each line. dia **Physician** resulting in death) /Medical Examiner plate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (of as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical use as the attending for use as IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) signed by the a 1□Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? es 2 No 1 ☐ Yes 2□ No 1□ Yes 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No director 26. Place of Death Check onl one Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

within 24 hours aft

To the Funeral Di

completely filled in the 0

5H-14+1

State Registrar

110 31. Date filed (Month, Day, Year)

NOV

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medica 32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

-06

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Morith, Day, Year)

32. pgistrar's Signature

		For State Registrar	State of Mary	•	artment of H			Reg. No.	006	396	
Physicia /Medic Examin	al	Decedent's Name (First, Middle, La:	nens		4b. City, Town, or	Location of Deat	2. Date of De Month	Day 26	year unty of Death	3. Time of 1	PM
Funeral Director		5. Social Security Number 6. S 240-32-9757	MM 2□E	yrs. last birthday) O Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir	th y, Year)	9. Birth Con NC	hplace (State or untry)	r Foreigr
Maryland 9-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD ANNE ARU		City, Town or Lo						10d. Inside City	
o within 72 hours after death with the Maryland jiene. Than' natural', or Items 23e or 28e-f show Ite Madical Examinet must be notified at	by Funeral Director	10e. Street and Number  791 OLD HERALD HA  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	RBOR RD.  12. Was Decedent Ever Armed Forces? 1 Types 2 □ No If Yes, Give Year or Dates: 195		10f. Zip Code 21032 Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (S In, Mexican, Puer Specify:		J <b>SA</b> - 14.	of What Con Race - Amer Black, White ecify:	rican Indian,	
should be filed within 72 nd and Mental Hygiene. s marked other than "natur umetic event, the Madical	To Be Completed	15. Decedent's E. (Specify only highest gra- Elementary/Secondary (0-12) 12  17. Father's Name (First, Middle, Last, PERCEY OWENS	College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired E POLICE	during most of wo	me (First, Middle	DEPT.		Industry	RES.
permir. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 is marke any injury or other treumetic once.		CINDY CORROW / EX  20a. Method of Disposition  1	Removal from State	Db. Place of Dispo cemetery, creat CHESAPEAK	ALTIMORE sistion (Name of natory or other place E CREMAT) 2. Name and Addrese ELLOWS, HI RE, 814 B	EON 11/	Date 28/2006 N & NEWN	20c. Locati STEVE	INSVILI	Town, State  LE, MD  N & FUNI	
Medical (Medical and parish transit the parish-transit the parish-tran	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Mary that intitated events resulting in death) Last	/	insequence of):	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Betw Onset and D	veen
ned by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d.	Date of deliment		'ear
has been signe 2 should be	Completed by Ph	Part II. Other significant conditions of	ontributing to death but no	t resulting in the u	nderlying cause givi	en in Part I.	1 24a. Was	an 24 24 24 25 25 25 25 25 25 25 25 25 25 25 25 25	4b. Were aut prior to c death?	the cause of de obably 4 Un topsy findings a completion of ca	nknow
r this certifice ral director, p	To Be	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Yea	2DER/Outpatier 28b. Time o Injury	f 28c. Injury Work	er: 4 Nursing t	ath (Check only of Home 5 Resi	one) dence 6 🗆			
within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Medical Certification:	3 Suicide 4 Homicide  6 Could not be determined  29a. Certifier (Check only one)  29b. Signature and title of certifier	building, etc. (S)  sysician: To the best of my niner: On the basis of exa and manner stated.	r knowledge, deat mination and/or in	h occurred at the tin vestigation, in my o	pinion, death occ	e, and due to the urred at the time,	vn, State) cause(s) and date and pla	d manner as ice, and due	to the cause(s)	
Sta	ate_	30. Name an ladd ess of erson who are 31. Date filed (Month, Day, Year)	completed cause of death  Completed cause of death  Completed cause of death  Completed cause of death  Completed cause of death	(Item 23a) (Type,	Print) Print) Print	643 fg	300 An	11/2	41200 MD 2	401	

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ivial	-	Certifica			R	leg. No. 2	006	39638
	Physicia	an	1. Decedent's Name (First, Middle, Last						2. Date of Dea Month	Day	Year	3. Time of Death
No.	/Medic		Joseph Rosaro F 4a. Facility Name (If not institution, give	orreca street and number)		4b. City	, Town, or	Location of Death	1. CACHIDE	- 4	2006 nty of Death	13
) V	Examin	er	Union Memorial				Ba	ltimore		Ba	altimo	re
89	Funeral		5. Social Security Number 6. Se		In yrs. last birti	Months	er 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	)	9. Birth	place (State or Foreign
(in	Director		172-22-0870 Usual Residence of Decedent	XVI ZUT		rs.			Nov 25	1926	Pen	nsylvania
	land ow at		10a. State 10b. County	1	0c. City, Town	or Location						10d. Inside City Limits
	Mary t-f shi fied a	ţċ	Maryland Washing	ton		Hager	stown					1 X Yes 2 □ No
	or 28g	Director	10e. Street and Number			10f. Zi	ip Code		1	10g. Citizen	of What Cou	ntry?
	ath wi		206 Division A					1740			S.A.	and Indian
	er de	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces? 1 Yes 2 No		If Yes, sp	edent of His ecify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. F	Race - Ameri Black, White,	
36	ırs aft al", or xami		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1	1/1946	1 ☐ Yes	2XNo	Specify:		Spe	ecity: Whi	te
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show thet, the Medical Examiner must be notified at	Completed by	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a.	Decedent's Us (Give kind of w	ual Occupa	ation Juring most of work	tina	16b. Kind o	f Business/In	dustry
2	ithin 7	mple	Elementary/Secondary (0-12)	College (1-4or 5+)				uring most of work		Fodo	ral C	vernment
7	lled w Hygiel ther tl		17. Father's Name (First, Middle, Last)	2	L	etense	Supp.	1y Specia 18. Mother's Nam				over inferit
ano	d be f ental l ced of	o Be	Camillo Porreca					Adeli	ina Teti			
Maryland	shoul nd Me mark umatř	ဥ	19a. Informant's Name/Relationship (7)	vpe. Print)	19b.	Mailing Addres	ss (Street a	and Number or Rui		r, City or To	wn, State, Zi	o Code)
	and 2		Edith V. Porreca	- wife		206 Div	visio	n Aye. Ha	gerstow	n Mary	land_	21740
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 [X] Cremation 3 ☐	Removal from State		Disposition (Na y, crematory or	ame of other place	θ)	Date	20c. Locatio	on - City or T	own, State
Baltimore,	t. Pag tment tant: tant:		4 ☐ Donation 5 ☐ Other (Specify	)	Smiths	burg Ci			-6-06			Maryland
Bai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	X I I I I		22. Name a		DC	ouglas A	. Fier	y Fund	eral Home yland 21742
	*	$\angle$	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the	ne death. Do r	ot enter the mo	ode of dying	g, such as cardiac	or respiratory ar	rest,	vii Mar	Approximate Interval Between
v =	Physician	i o	Immediate Cause (Final	Multio		dusti						Onset and Death
1	/Medical		disease or condition resulting in death)	Due to (or as a	o n equence o	of):						
	Examiner		Sequentially list conditions	b. Sepsis	wit		ngen	Ma				4 weeks
	ed	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	-	1000.10	1					4 weeks
	execut and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a		of):	- 1					9 000-2
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical I		d								
	ntifica ng ph	Medi	IF FEMALE:									_
Box	that the death cer ed by the attendin detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pt 1☐Live birth 2	Fetal death					23d.	Date of delive	rery Day Year
P.O. I	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me or death	5 ☐ Other (	specity)					
٦	that the	y Ph	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying	cause give	en in Part I.	23e. Did to	bacco use c	contribute to	the cause of death?
rds	quires en sign uld be	q pa							1 🗆 Y	res 2 □ N	o 3□Pro	bably 4 Unknown
900	law requires that as been signed b 2 should be deta	Completed by							24a. Was autop		4b. Were aut	opsy findings available ompletion of cause of
E B	i <b>cian:</b> The lar certificate has rector, page 2	Com							perfo 1□ Yes	rmed? 2 No	death? 1 □ Yes	2 □ No
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Othe	26. Place of Dea				
o	Phys r this ral dir	은 -:-	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. 1	tpatient 3□ [ Firme of	28c. Injun	4 Li Nursing H	ome 5 Resid			ify)
lon	Attending r death. ector: After by the fune	tion	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) 1	njury M		<br Yes 2 □ No				
Division or Vital Records,	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injur building, etc.	y - At home, fa (Specify)	rm, street, facto	ory, office		28f. Location (S City or Tox		umber or Ru	ral Route Number,
	Hospital or 24 hours afte Funeral Dir tely filled in		and of the second secon		i mare lemanado de ma	dooth occurre	ad at the time	no data and place	and due to the		d manner as	etated
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical		ysician: To the best of niner: On the basis of e and manner state	examination an							
	To the l	Me	29b. Signature and title of certifier	- a -		2	29c. License	e number	,	29d. Date si	gned (Month	, Day, Year)
			Mull	- Mi	,)	/	4T2	43894	6	Nove	mber	28,2006
,			30. Name and address of person who	completed cause of dea	ath (Item 23a)	(Type, Print)	1 11	20/1/	2 14242	0 #	/ > -	28,2006 1218
2	11-12+1		31. Date filed (Month, Day, Year)	32. Begistrar	r's Signature	emor (a	1 110.	spile! !	allimor	- M	D, 2	1218
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	106 Dinger	J. 13.	Sperks	1					

Registrar

			1 - For State Registrar	State	of Marylar		artment <i>tificate</i>			d Mental H	ygien Rag. N	2006	39640
	Physici	an	1. Decedent's Name (First, Middle, La	1	D . 1. C	<i>c</i>				2. Date of Month	Death		3. Time of Death
	/Medic	al	Ana Maria  4a. Facility Name (If not institution, giv.		Ratlif	İ	4b. City. T	Fown or L	ocation of De			8, 2006 c. County of Deat	12:26P.M
	Examin	ier	Laurel Regional H		_			Laurel				rince Ge	
	Funeral Director		5. Social Security Number 6. S 213-92-2250	ех □м <b>2/</b> □F	7. Age (In yrs. 61	. last birthday) Yrs.	If Under Months		If Under 24 H Hours N		Dav. Year	9. Birtl 1945	nplace (State or Foreign unity) Chile
	land		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation					-	10d. Inside City Limits
	e-feh	ctor	Maryland Montgo	omery		E	Burton	svil	<b>l</b> e				1 □Yes 2 □ No
	with th	Dire	10e. Street and Number				10f. Zip	<sup>Code</sup> 2086	<u>د</u>		-	itizen of What Co ited Sta	•
	death me 23	Funeral Directo	3671 Childress Te	12. Was De	cedent Ever in L	J.S. 13.1	Was Decede	ent of Hisp	anic Origin?	? (Specify Yes or	1	14. Race - Ame	rican Indian,
336	should be filed within 72 hours after death with the Maryland Ind Mental Hygene. marked other than "naturel", or lieme 23a or 28a-f ehow maric event, the Medical Exament must be notified at	by	1 ☐ Never Married 2 🌠 Married 3 ☐ Widowed 4 ☐ Divorced	Armed F 1 Yes If Yes, G Year or	2 (XNo Sive		t Yes, speci 1 X Yes 2	-	Mexican, Pu Specify:	uèrto Rican, etc.) Chilean		Black, White Specify: Whi	•
r S	72 hou	eted	15. Decedent's Ed (Specify only highest gra		")	(Give	dent's Usual	k done dur	on ring most of	working	16b. I	Kind of Business/	ndustry
121	l within iene. r than	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)		oo not usa Iomema					Own Horr	ie
Maryland 21215-0036	id be filed lental Hygi rked other ilc event, I	Be	17. Father's Name (First, Middle, Last,		D 11			1/		Name (First, Mide			
<u> </u>	2 should be and Mental le marked c	ပ	Jorge Martine  19a. Informant's Name/Relationship (		Balles		g Address	(Street and	Maria Maria		nella nber, City	or Town, State, 2	
	s 1 and 2 should if Health and Mer item 27 le marke other traumatic		Paul E. Ratliff,			3671	hildr	ess '		ce, Burto	-		20866
ore e	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disposition  1 Burial 2 Cremation 3		n State	Place of Dispo cemetery, crer	natory or oti	her place)	•	Date		ocation - City or	
altimore,	permit. Pages 1 Department of H Important: If ite any Injury or ott		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer		Me	22	. Name and	Address	of Facility	.1-20-06			Virginia
<u>~</u>	Der Imp		Honald Up	rec	ract	<u>D</u> 2	pnald +00 Pc	V. Bowder	orgwar MYII	Road, Be	al H Itsv	ille, Pi	20705
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final						such as card	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	ω	ardiopul o (or as a conse		Arres	st					
	Examiner	er	Sequentially list conditions,	D	oronary		Disea	ase					
	cuted nd ransit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С.	, , , , , , , , , , , , , , , , , , , ,								
8760,	cate be executed physicien and the burial-transit	a Ex	resulting in death) Last	Due to	o (or as a consec	quence of):							
		ledicai		_ d									
. Box	that the death certified by the ettending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1□Live	utcome of pregn birth 2 Pet	aldeath 3□	Ectopic pre					23d. Date of deli	very Day Year
р. О.	the de	hysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4⊟Preg 9⊟Unk	nant at time of one	death 5	Other (spe	ecify)					
<u>s</u>	89 20 9	2	Part II. Other significant conditions of Ascites; Dementic		death but not re	sulting in the u	nderlying ca	iuse given	in Part I.			V	the cause of death?
S S	w requir been si should	eted	,							24a. W			topsy findings available
Division of Vital Records,		Completed								- au	topsy rformed?	prior to death?	ompletion of cause of
VIII V	ysician: T	Be	25. Was case referred to medical examiner?	Hospital:	7.	,				Death (Check onl			
ō	ding Phys h. After this funeral di	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date		ER/Outpatien		A Carron a Work?	4 🗀 (40) 3111	g Home 5 Re 28d. Describ		6 □Other (Spec	ufy)
SIO	Attendin death. ctor: Aft y the fun	catio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	n		Injury	М	1 □ Ye	s 2 □No				
2	tal or Atten is after deat al Director: ed in by the	Certification:	4 Homicide determined	200. Plat	ce of Injury - At h ding, etc. (Speci	nome, farm, str ify)	eet, factory,	office			(Street a own, Stat		ral Route Number,
	To the Hospital or Attending Physician: within 42 hours after death.  To the Funderal Director: After this certific completely filled in by the funeral director,	Medical (	29a. Certifier 1 Certifying Ph (Check only 2 Madical Examone)	ninar: On the	ne best of my knobasis of examination	owledge, death ation and/or in	occurred a restigation,	t the time, in my opin	date and plaining date and plaining death of	ace, and due to the	e, date an	s) and manner as ad place, and due	stated. to the cause(s)
	To th within To th compi	Me	29b. Signature and title of certifier	7111	7 -			License n				ate signed (Month	
1	6		* Receipt	all	rent	(1)		JZJI3	<i>'</i>		NOV	rember 20	, 2006
			30. Name and address of person who Henry Willner, M	.D. 730	00 Van D	ousen Ro	oad La		, Mary	yland 20	707		
	Sta	te	31. Date filed (Month, Day, Year)	2006 32.	egistrar's Sign	ature	and ?						

				artment of Health and Me rtificate of Death	ental Hygiena () ()	6 39641
4	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> THOMAS LEE STEWART			3. Time of Death Year 1355 M
	/Medie Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of	
	Funeral Director		Memoria Hospita 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday $215-42-7837$ 1 M $2\square F$ 61 Yrs.	If Under 1 Year If Under 24 Hrs. 8	B. Date of Birth	9. Birthplace (State or Foreign Country) California
9	land low		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits
	Ba-f eh	ctor	MD Caroline	Federalsburg		1 X Yes 2 □ No
	3a or 2	i Dire	10e. Street and Number 219 S. Main Street	10f. Zip Code 21632	10g. Citizen of Wh	
036	be filed within 72 hours after deeth with the Maryland that Hygiene. od other then "natural", or items 23a or 28a-f ehow event, the Medical Examinar must be muilled at	by Funeral Director		Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Ri 1 ☐ Yes 2 No Specify:	ify Yes or No- lican, etc.)  14. Race Black, Specify:	American Indian, White, etc. White
21215-0036	트 - 목	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	ident's Usual Occupation  a kind of work done during most of working  DO NOT use retired)  Lumber	Mecha	•
Maryland ?	should be filed witt nd Mental Hygiene marked other the matic event, ''ne''	To Be C	17. Father's Name (First, Middle, Last) Thomas LeRoy Stewart		First, Middle, Maiden Sumame, aurine Tucke	
lary	2 a 2	-		ing Address (Street and Number or Rural)	Route Number, City or Town, S	tate, Zip Code)
	is 1 and of Health item 27 other tr		20a. Method of Disposition 20b. Place of Disp	31 Paradise Lane		MD 21636 lity or Town, State
Baltimore,	Page nent o ent: If		1 Buriai 2 Y Cremation 3 Hemoval from State	matory or other place)  Shore VA 12/4	/06 Hurloc	k, Maryland
Ball	permit. Pag Department Importent: any injury once.			2. Name and Address of Facility  Framptom Funeral	Home, PA,Fe	Maryland deralsburg,
	Dhuaisian		23a. Part1. Enter the disease, or complications that caused the deeth. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	ter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)  a. Due to (or as a consequence of):	camia		
		ner	Sequentially list conditions, if a y, leading to limit ediate cause. Enter Underlying Cause (Disease or injury			
,0	icate be executed physicien and s the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last			
68760,	ficate by physic is the bu	edicai	d			
P.O. Box	The law requires that the death certifi ate hes been signed by the attending I page 2 should be detached for use as	Physician/M		□Ectopic pregnancy □ Other (specify)	23d. Date Monti	
	quires that the de n signed by the a uld be detached f	ρ	Part II. Other significant conditions contributing to death but not resulting in the i	01	23e. Did tobacco use contrib	oute to the cause of death?
Vital Records,	The law requisate hes been page 2 should	Completed	0,5295-2		autopsy pri performed? de	ere autopsy findings available or to completion of cause of ath?
Vita	Physician: T this certifical ral director, p	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Hospital: 2 ER/Outpatient	26. Place of Death (		
ion of	D 0 0	ation: To	1	A Nursing Home	e 5 Residence 6 Other d. Describe how injury occurred	
Division	To the Hospital or Attending will in 24 hours after death. To the Funeral Director: After completely filled in by the fun	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28	lf. Location (Street and Number City or Town, State)	or Rural Route Number,
	e Hospit 24 hours e Funera	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check one)  Certifying Physician: To the best of my knowledge, deal (Check one)  Certifying Physician: To the best of my knowledge, deal (Check one)  Certifying Physician: To the best of my knowledge, deal (Check one)  Certifying Physician: To the best of my knowledge, deal (Check one)  Certifying Physician: To the best of my	th occurred at the time, date and place, an ovestigation, in my opinion, death occurred	d due to the cause(s) and mann d at the time, date and place, an	ner as stated. d due to the cause(s)
=	To the To the comp	2	29b. Signature and title of certifier	29c. License number	29d. Date signed (	
			30. Name and address of person who completed cause of death (Item 23a) (Type	Doo 53110		~ 29,2004
	or brace of		Dr. Dennis M. DeShiels, 219 5.  31. Date filed (Month, Day, Year)  32. Registrar's Signature		Easton, Md.	21601
(E)	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	and the F		

Stewart, Thomas Lee

State of Maryland / Department of Health and Mental Hygiene 0 0 6 39642 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 2006 8:53 Gladys Emma Steward /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Denton Caroline Home for Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2□F Yrs. 86 Director August 14, 1920 Maryland 219-48-4319 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 ie marked other than "naturel", or iteme 23a or 28e-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 ie marked other than "naturel", or iteme 23a or 28e-f ehow other treumatic event. The Madical Examinar must be notified at 1 Yes 2 No Maryland Directo Denton Caroline 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21629 United States of America 25900 Shore Highway Funerai 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž☐ No Specify: Caucasian Specify: Š If Yes, Give Year or Dates: 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Care Provider 11 HS Grad Private Sitter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anita Eberhardt 2 Clarence Wooters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 25900 Shore Highway, Denton, Maryland 21629 Beverly Harris 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate Date 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If eny Injury or once. Denton Cemetery Denton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, 21. Signature of Funeral Service License auchfill Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) gaubiadder ca **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Examine the attending physicien and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence ol): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown è Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? ď cete hes been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy lindings available prior to completion of cause of death? this certificate has 2 🗆 No 1 Yes 2 No 1 TYes To the Hospital or Attending Physician: : Alter this certification funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Wother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/OutpatienI Certification: To 1 ☐ Yes 2 No 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Mannet of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the riversus after death.

Within 24 hours after death.

To the Funeral Director: All 1 ☐ Yes 2 ☐ No М 2 Accident investigation 6 □ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. D., 29466 Pintail Drive, Easton, Maryland 21601 David Smith, 31. Date filed (Month, Day Year) 32 Registrar's Signature State Registrar

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygien ? 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** В. Travers November 23 2006 1406 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner a/ bo 7 Easton Memorial Hospital The If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 31, 1948 5. Social Security Number 6. Sex 7. Age (În yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ TF 57 Yrs. 217-52-0231 Maryľand Director Usual Residence of Decedent the Marylend 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ?7 ie marked other than "neturei", or items 23s or 28s-f ehow traumatic event, ite Madical Examinat must be notified al 1 ☐ Yes 2 ☑ No Director MD Caroline Preston 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 101 Harmony Road 21655 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes To Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Harlon P. Blades Thelma Mowbray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 : Department of Heelth ar Important: If Item 27 ie eny injury or other trau 9DCE. Matthew Travers/Spouse 101 Harmony Road, Preston, MD 21655 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mid-Shore Cremation 11/24/06 Cambridge, Maryland 22. Name and Address of Facility ramptom Funeral Home, P.A. 21. Signature of Funeral Service Licenses Muhael 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 09.5 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Disease or injury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Sunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☑ 1√0 No 1 Yes within 24 hours effer death.

To the Funerel Director; After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ≥S No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 24, 200 6 D0053110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. Washington MD 2160 Easton 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

28

2006

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			For	State of Marylar	•			Mental Hygi	ene nns	39666
			1 - State Registrer		Certif	icate of De	eath	Re	g. No.	0 0 0 1 1
	Physicia		1. Decedent's Name (First, Middle, Last)	Valle		•		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s	1 1	12.R. 4t	City, Town, or Lo	١.		4. County of Dea	
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) If	Under 1 Year	ONS FUnder 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	thplace (State or Foreign
	Director		Usuat Residence of Decedent	M 2□F	Yrs.	Jays 1	56		2006 1	akerland
Maryiand	or 28a-f show	tor	10a. State 10b. County		ty, Town or Location					10d. Inside City Limits 1 ☐ Yes 2 No
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2 should be filled within 72 hours after death with the Maryland	or Iteme	y Funeral	1 Never Married 2 Married	2. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 No If Yes, Give		Decedent of Hispa s, specify Cuban, I Yes 2 No		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
2 hours	"naturel", edical Exp	ted by	3 Widowed 4 Divorced  15. Decedent's Educ	Year or Dates:	16a. Decedent	's Usual Occupatio	on .	1	6b. Kind of Business	s/Industry
within 7	r then "n tre Med	Completed	(Specify only highest grade	College (1-4or 5+)	life DO	d of work done duri NOT use retired)	ing most of won	king	nlA	
t be filed	of Health and Mental Hygiene. Item 27 is marked other then other treumatic event, tre Mi	Be	17. Father's Name (First, Middle, Last)	Jalla	,	18	1	e (First, Middle, M.	aiden Sumame)	200
houle	d Me nark	ပ	19a. Informant's Name/Relationship (Type	DE Print)	19h Mailing A	ddross (Street and	Number or Bu	oledaa	City or Town, State,	Zin Code)
and 2 s	ealth an n 27 ie eer treu		Flor Valle Qui	Rino/Hother	208	Brown 1	Woods	Rd, An	rapolis, 1	Md 21409
Pages 1	Department of Health a Important: If item 27 is any injury or other tre		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □R 4 □ Donation 5 □ Other (Specify)	emoval from State	Place of Disposition cometery, cremator tro Crem.	ory or other place)	1		oc. Location - City o Baltimore	
permit.	Departm Importa any inju pnce		21. Signature of Funeral Service License	*L	На		uneral l	Home P.A.	27724	
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DIVISION OF VITAL INCOMINGS, IT.O. DOX OUT OUT.	been signed by the ettending phys should be detached for use as the	Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 6	al death 3 Ect	opic pregnancy her (specify)			23d. Date of de Month	elivery Day Year
uires that t	signed by Id be detai	þ	Part II. Other significant conditions con	tributing to death but not re	sulting in the under	rlying cause given i	in Part I.	23e. Did toba	V	to the cause of death?  Probably 4 Unknown
aw req	has beer ge 2 shou	Completed						24a. Was an autopsy		autopsy findings available completion of cause of
The The	this certificete had director, page							perform 1 Yes 2	ed? death? No 1 □ Ye	
iclan	ector •	Be	25. Was case referred to medical examiner?	ospitat:		Other		th Check only one		
2 g	this ral dii	<u>P</u>	1 ☐ Yes 2 No  27. Manner of Death	ospitat: 1 Inpatient 2 2	28b. Time of	3LI DOA		ome 5 Resider 28d. Describe how	ce 6 Other (Sp	ecify)
uding	eath. or: After he fune	atlon	1 Statural 5 Pending investigation	(Month, Day Year)	Injury	28c. fnjury at Work? M 1 \(\sum Yes	s 2□No	20d. Describe not	Vinjury occurred	
tal or Att	within 24 hours after death. To the Funerei Director: After this certificete hi completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special		factory, office		28f. Location (Stre City or Town,		Rural Route Number,
Hospii	24 hour Funer etely fill	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemir	icien: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death oc ation and/or invest	curred at the time, igation, in my opini	date and place, ion, death occur	and due to the car rred at the time, da	use(s) and manner a te and place, and du	as stated. se to the cause(s)
o th	ompl	Me	29b. Signature and title of certifier	. 1 .		29c. License n	umber	29	d. Date signed (Mor	nth, Day, Year)
_	, F 0		Dr W. Kallai	t HEO Leade	unRes	DOC	32-33	15	12-66	,-2006
			30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, Prin		. 2140	) (		
	Sta Registi		31. Date filed (Month, Day, Year)	22. Registraris Sign	- 11	3				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] [ ] For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 27 2006 Nov. Ethel Marie C. Weaver 6:05A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Denton Caroline Caroline Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. March 24 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🕅 F 1919 87 Maryland 218-10-3207 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County rai', or items 23a or 28e-f show Examiner must be nutilised at 1 ☐ Yes 2 ☐ No Caroline Greensboro Maryland Direct the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12583 Ridgely Road U.S.A. 21639 death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: if Yes, Give Year or Dates: Specify: ģ 3 X Widowed 4 □ Divorced White "natural" the Medical Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) of Health and Mental Hygiene. If item 27 is marked other than or other freumatic event, if a M homemaker own home 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Fred Cohee Ethel Irwin Cohee 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12583 Ridgely Road; Greensboro, Maryland 21639 George Weaver/ son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Greensboro Cemetery 11/30/2006 Greensboro, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) Fleegle and Helfenbein Funeral Home, PA PO Box 160 Greensboro, Maryland 21639 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebro viascular Physician 245 resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760 attending physician Completed by Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year detached for in the past 12 months? 5 Other (specify) ☐Yes 2☐No Ö the 9☐ Unknown 9 Unknown þ Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 8 1 ☐ Yes 2 🗗 🐪 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕅 No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred in by the funeral 27. Manner of Death s after death. Certification: Injury 1/28Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide peliil 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely

State Registrar

31. Date filed (Month, Day, Year) 0

Zaki 920 Market

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Street,

29b. Signature and title of certifier



**ORIGINAL** 

Denton, MD 21629

29c. License number

Doc47534

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

within 2

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		-	For State		State of Ma	aryland		epartment of F Certificate of		nd Mer			71116		39646
			Registrar  1. Decedent's Name	(First, Middle, La					Dealii	2.	Date of De	Reg. No.			3. Time of Death
Phys	sicia edica		Robe	Vt E	vans	W	12	en, Dr		A.	Month	Day			57 55 AM
Exan			4a. Facility Name (If r			1 100	25	4b. City, Town, o	r Location of				County of De		
			5. Social Security Nur	B BIS	PARM	e (In yrs. la:		Jav) If Under 1 Year	If Under 24	1 Hrs. o	E Date of Black		CEC	1	(0)
Funer Direct			160-24-05	1	M 2□F	79 <i>(111 yrs. 1</i> 21		Months Days	Hours	Min. 0	Date of Bird (Month, Da 6/08/	n y, Year) 1927	9. B	ountry)	e (State or Foreign PA
p ,			Usual Residence of D	Decedent 10b. County		10a Cib.	T								
/anyla		5	MD	CECIL		EARL		or Location							Inside City Limits  1 Yes 2 No
the N		Director	10e. Street and Numb			LAKL	LVI.	10f. Zip Code				10a. Citi	izen of What (		
th with 23a o		<u>a</u>	191 BOB E	BIS FARM	LANE			21919					SA	,	
r dea		Funeral	11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.S.		13. Was Decedent of I	lispanic Origi an, Mexican,	n? (Specify Puerto Rica	Yes or No		14. Race - An Black, Wh		Indian,
5-0036 72 hours after death with the Maryland natural; or Items 23a or 28a-f show and East-direct, wat be notified at		by Fi	1 Never Married 3 Widowed 4		1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	10		1 ☐ Yes 2 💆 No	Specify:				Specify: W		
72 hours a			/Sancife	5. Decedent's Ed	ducation	Ī	16a. D	ecedent's Usual Occup	pation	-4d.i.a -		16b. Ki	ind of Busines	s/Indust	try
vithin 7	i i	Completed	Elementary/Second	, , ,	College (1-4or 5	+)	11	Give kind of work done fe. DO NOT use retire ARMER	d) most c	or working			OD T 0111		
filed w Hygiei ther ti		e Co	17. Father's Name (F				E A	ARMER	18. Mother	s Namo /Fi	iret Middle		GRICUL:	LURE	
yland ould be fil Mental Hy arked oth		0	EVANS WIL						EDNA I		ist, middie,	Maidell	Surriame)		
ary shou and M s mar		-	19a. Informant's Nam				19b. N	Mailing Address (Street			oute Numbe	er, City o	r Town, State,	Zip Co	de)
and 2 st and 2 st ealth and n 27 is r			SANDI TRA		HTER			B HICKORY I	ORIVE,	BEAR,	, DE	1970	1		
DENTIMOTE, METYIERIG ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, ITE Muchal Ext. «Illings and be notified at				Cremation 3	Removal from State	cen	netery,	isposition (Name of crematory or other plan		Date			ocation - City o		
Daltimo		-	`4 ☐ Donation 5			ST.	MA'	CTHEWS CEME 22. Name and Addre		12/01/	/2006	CHE	STER SI	PRIN	GS, PA
Deg E	Suc		from.	filler				FELLOWS, F 130 SPEER	ELFENE ROAD	BEIN A	AND NE	EWNAI	M FUNE	RAL	HOME, PA
			23a. art1. Enter the shock, or heart	disease, or com failure. List only	plications that caused one cause on each lin	the death.	Do no	enter the mode of dyir	ng, such as ca	ardiac or re	spiratory ar	rest,	2,102	Ap	proximate erval Between
Physicia			Immediate Cause (Fi disease or condition resulting in death)	inal	a. Musica	rdia	(	Infarct	100						set and Death
/Medica	_		resulting in death)	(	Due to (or as	a conseque	nce of)	:							
		Je.	Sequentially list cond if any, leading to imm	ditions, nediate	b. Due to (or as	a conseque	ence of)	:							
cuted nd ransit		Examiner	cause. Enter Underly Cause (Disease or in that initiated events		C										
cate be executed physician and sthe burial-transit	!	EX	resulting in death) La	SI	Due to (or as	a conseque	nce of)	:							
ficate be e physiciar the buria	:	edical			d										
death certif	1	Ž	IF FEMALE: 23b. Was decedent p		23c. If yes, outcome			200				1	23d. Date of d	elivery	
GOLGS, P.O. BOX O requires that the death certific been signed by the attending p should be detached for use as		Physician/M	in the past 12 m		1□Live birth 4□Pregnant at 9□Unknown			3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	/				Month	Day	y Year
hat the set by the detach	i		9 Unknown Part II. Other signific	ant conditions		it not result	ing in th	ne underlying cause giv	en in Part I		23a Did to	phaceo !!	sea contribute	to the c	ause of death?
law requires that the as been signed by the 2 should be detached		<u> </u>			,			io andonying addoo gre	on are are a						4 🗷 nknown
aw req s beer 2 shou		olete									24a. Was	an	24b. Were a	utopsy	findings available
VICAL THE SALCENT: The law certificate has be rector, page 2 s		Completed									autop perfo 1 Yes	rmed? 2 8 No	prior to death?	comple	etion of cause of
VICAL Iclan: 7 certificat ector, pa		Be	25. Was case referre	d to medical					26. Place o			,			
Physic rthis c	ı	2	1 Yes 2 No.	0	Hospital: 1 ☐ Inpatie		· · · · · · · · · · · · · · · · · · ·		4 🔲 Nurs				6 ☐ Other (Sp	ecity)	
on ading th. : After s funer		ertification;	1 Matural 2 ☐ Accident	5 Pending investigation	28a. Date of Injur (Month, Da)	Year)	8b. Tim Inju	iry Wor	yat k? Yes 2 ∐ No	i	Describe h	iow injur	y occurred		
VISION Attending or death. rector: Afte		tifica	3 Suicide	6 Could not b		ury - At hom	ne, farm	street, factory, office			Location (S		d Number or F	Rural Ro	oute Number,
urs aft		O													
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:		edical	29a. Certifier 1 (Check only 2 one)	Certifying Ph	ysician: To the best on niner: On the basis of and manner sta	examinatio	ledge, o on and/o	death occurred at the tir or investigation, in my o	ne, date and prinion, death	place, and occurred a	due to the out the time,	cause(s) date and	and manner a place, and du	s stated e to the	i. cause(s)
To th withir To th		Me	29b. Signature and tit	tle of certifier				29c. Licens	e number				e signed (Mor		,
			106	5 mi	>	MD			3309	7	٨	Vaserv	ber 27	th (	2006
			30. Name and address	s of purson who	completed cause of de	MD L	Inior	+ Hospital E	Ikton.	mD	214	991			
	Stat		31. Date filed (Month,		82. Regiona	ar's Signatu	re	Sporte							
Regi				NOV 29	200	1cm	D.	Apoll							

			State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death  Reg. No.	11111 3964/
	Physicia /Medic	an al	70 Z	2006 12:10/M
	Examin Funeral Director			County of Death  REDERICK  9. Birthplace (State or Foreign Country)  PA
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ✓ Yes 2 ☐ No
	th with the 23s or 28 ust be not	Funeral Director	10e. Street and Number 10f. Zip Code 21703	itizen of What Country?
900	s 1 and 2 should be filad within 72 hours after death with tha Maryland of Health and Mentai Hygiena. item 27 Is marked other than "natural", or Itams 23s or 28a-f show other traumatic event. Its Marylal Examinations at the marities at	þ	3 Widowed 4 □ Divorced If Yes, Give 1□ Yes 274 No Specify:	14. Race - American Indian, Black, White, etc.  Specify: BLACK
21215-0036	d within 72 h giena. ar than "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)	Kind of Business/Industry
Maryland	should be filad withir ind Mental Hygiena. I markad other than umatic event. Its M	To Be C	17. Father's Name (First, Middle, Last)  PEARUE PRATT  18. Mother's Name (First, Middle, Maide)  MARY BRUCE	
	1 and 2 shd Health and tem 27 is m		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City  1204 DANIEUE DR. FREDERICK	or Town, State, Zip Code) MD. Z170Z
altimore,	00 0		1 Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  1 Donation 5 Other (Specify)	won Hill, Pa.
Balt	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Libensee 22. Name and Address of Facility CARY L. ROLL  110 WEST SOUTH ST. FREAKRICH	c, mo 21701
	Pnysician /Medical Examiner	-6	23a. Part 1. Enter-Me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter tribuging to immediate cause. Enter tribuginging	Approximate Interval Batween Onset and Death Mon Wy
68760,	death certificate be executed e attending physician and ad for use as the burial-transit	dical Examiner	cause (Disease of Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d	
P.O. Box 6	that the death certifica ad by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23d. Date of delivery Month Day Year
ecords, P	The law requires that the tee bas been signed by the bage 2 should be detache	þ	Part II, Other significant conditions continuiting to death out not resulting in the underlying cause given in Part I.	use contribute to the cause of death?
$\alpha$		Completed		24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
Vital	Physicism: rthis certificaral director,	o Be	examiner?	6 Other (Specify)
ion of	Jing After fune	-1		
Division	tal or Attendi s after death. sl Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street a building, etc. (Specify)	nd Number or Rural Route Number, e)
	To the Hospital or Attent within 24 hours after death To the Funers! Director: completely filled in by the	Medical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(some death occurred at the time). To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and place, and due to the cause(some death occurred at the time).	d place, and due to the cause(s)
)	To the To the Company	Σ	D43091 1	ate signed (Month, Day, Year)
9	H-3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Size of Zaidi MD 801 Toll House Are Frede  31. Date filed (Month, Day, Year)  32. Registrar's Signature  Signature	rick, MD
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 1 2006  32. Registrar's Signature  Special St. Special St.	,

Type of Time in Bia	ok maonoro mk.	Ellouic All C	opies Ale Le
State of Maryland /	Department of H	ealth and Mor	tal Hygiana

			State of Maryland / Departs State of Maryland / Departs State Registrar	rtment of Health and M t <i>ificate of Death</i>	iental Hygier Reg.	2006 20610
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic		Chacko C. Yogiaveetil			r 25, 2006 3:55 PM
	Examin			4b. City, Town, or Location of Death		4c. County of Death
			Holy Cross Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	Silver Spring If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Montgomery  9. Birthplace (State or Foreign
ŀ	Funeral Director		236-06-9619 <sup>1X□ M 2□ F</sup> 61 <sup>Yrs.</sup>	Months Days Hours Min.	(Month, Day, Ye. June 2, 1	ear) Country)
	D		Usual Residence of Decedent	-41	ounc 2, 1	
	arylar show	'n	10a. State 10b. County 10c. City, Town or Local	ation		10d. Inside City Limits 1  ☐Yes 2  ☐No
	the M 28a-f lotifie	Director	Maryland Montgomery Silve  10e. Street and Number	er Spring	100	Citizen of What Country?
	with 3a or it be		1131 University Blvd, West, #2102	20902	1.09.	USA
	death	Funeral		/as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
5-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 📆 Married 1 ☐ Yes 2 📆 No	Yes 2 No Specify:	nican, etc.)	Black, White, etc.  Specify: Asian Indian
50	72 ho natur dical	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation ind of work done during most of work	ing 16b	. Kind of Business/Industry
12	vithin than " le Me	шb	Elementary/Secondary (0-12) College (1-4or 5+)	O NOT use retired)		
2	filed v Hygie other t	ပိ	17. Father's Name (First, Middle, Last)	ear Medicine Techr	nologist e (First, Middle, Maid	Medical
Maryland	should be nd Mental marked o	To Be	Chandy Pothen Yogiaveetil		C. Palack	·
ary	2 should   and Men is marker aumatic	-	19a, Informant's Name/Relationship (Type. Print) 19b. Mailing			ity or Town, State, Zip Code) 20902
Σ̈́	₽ £ 7 ₽		Annamma C. Yogiaveetil/ wife 1131	University Blvd,	W., #2102	2, Silver Spring, MD
altimore,	Pages 1 ient of He nt: If Iten ry or oth		1 KD urial 2 Cremation 3 Hemoval from State	ition (Name of latory or other place)  Nov.	28,	c. Location - City or Town, State
Balti	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility ancis J. Collins	Funeral H	
			23a. Part1. Enter the disease, or complications that causing the death. Do not ente shock, or heart failure. List only one cause on each line.			
	Physician		Immediate Cause (Final disease or condition a. Acute Myocardial I resulting in death	<u>. u</u> 199		Onset and Death
1	/Medical					
. 6	Examiner	_	Sequentially list conditions, b. Asystole			
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is interded experts.			
Ć,	icate be executed physician and s the burial-transit	Examiner	that initiated events c			
68760,	te be ysicia re bur	edical	<b>L</b> d			
		Med	IF FEMALE:			
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burfal-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No  23c. If yes, outcome pt pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐  4 ☐ Pregnant at time of death 5 ☐	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
P.O.	res that the de signed by the a be detached f	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the un-	derlying cause given in Part I	23e Did tobaco	co use contribute to the cause of death?
ords,	w requires to been signed should be considered.	ted by	Thoracic and Abdominal Aneurysm, Chu	rg-Strauss Syndro	m	2 No 3 Probably 4 Unknown
or Vital Records,	The law rate has be	Completed			24a. Was an autopsy performed 1 Yes 2 ☑	24b. Were autopsy findings available prior to completion of cause of death?  No 1 \sum Yes 2 \sum No
/ita	ding Physician: The n. After this certificate h. funeral director, page	Be C	25. Was case referred to medical examiner?		h (Check only one)	
<u>_</u>	Physic this c al dire	မ	1   Yes 212 No   Hospital: 1   Inpatient 2   ER/Outpatient			e 6 Other (Specify)
UC C	ding F	ion	27. 1 Manner of Death 28a. Date of Injury 28b. Time of Injury (Month, Day Year) 2 Accident investigation 2 Accident	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how it	njury occurred
Division	Atten death cctor:	ficat	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, stre		28f. Location (Street	et and Number or Rural Route Number,
<u>S</u>	al or / after I Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	tate)
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director, t	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death one)  Medical Examiner: On the basis of examination and/or invalid manner stated.			
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			Dagueso de Sain	D13548	Nov	vember 27, 2006
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, F Rajindra K. Sarin, M.d 1500 Forest	Glen Road, Silve	r Spring,	MD 20910
	Sta Regist		31. Date filed (Month, Day, Year)  NOV 2 8 2006  32 Règistrar's Signature			

		Please	Type or Prin	aryland / Depa	delible Ink. Ensuartment of Health a	and Mental Hy	giene	3964			
		Registrar		Cel	tificate of Death		Reg. No.	10 Time 45			
Physicia /Medic		1. Decedent's Name (First, Middle, La	uderson	j		2. Date of De Month	Day Year	3. Time of Death			
Examin		4a. Facility Name (If not institution, gr	ve street and number)		4b. City, Town, or Location of	of Death	4c. County of De	ath			
Funeral			Sex 7. Ag	e (In yrs. last birthday)	Months Davs Hours Min. (Month, Day, Year)						
Director		Usual Residence of Decedent  10a. State  10b. County	8	Yrs.	ocation	HUEWIT	81702 NA	10d. Inside City Limit			
with the Maryland a or 28a-f show	Director	Madeo Lui		Tonous	040			1 □ Yes 2 <b>X</b> N			
ith th		10e. Street and Number	- *		10f. Zip Code		10g. Citizen of What C	country?			
ath wi	8	213 OUTEN C	RIVE		21918		V.2.4	- does lading			
n 72 hours after death with the Maryla "naturel", or Iteme 23a or 28a-f shov adical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ➡ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2	No	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar 1 ☐ Yes	n, Puerto Rican, etc.)	o- 14. Race - Arr Black, Wh				
72 hours "naturel", adical Ext	b F	15. Decedent's E		16a Dece	dent's Usual Occupation		16b. Kind of Busines	s/Industry			
2 should be filed within 72 and Mental Hygiene. Is marked other then "nafeumatic event, the Madic	Completed	(Specify only highest gi	College (1-4or 5	(Give	kind of work done during mos DO NOT use retired)	st of working	AT Un	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~			
lled v lygie her i	ပိ	17. Father's Name (First, Middle, Las	1)	370		er's Name (First, Middle	e. Maiden Sumame)	1. 1			
be fi	Be	1/ Patrier's Name (Prist, Middle, Eds	10		P	10 00 1	\. == co. co.				
s 1 and 2 should be filed within f Heelth and Mental Hygiene. Item 27 is marked other then other treumatic event, the M	2	THICKY H	- 1/02 (57	10h Maili	ng Address (Street and Number	Por or Pural Pouts Numi	tor City or Town State	Zin Codel			
2 sh and lis rr		19a. Informant's Name/Relationship	(Type, Phili)	19b. Malli	ng Address (Street and redinor		6.0	0.01015			
theeth theeth them 27 other tr		7571.8 5 HUMS	1500	20b. Place of Dispo	SVI SA JAZIVE	Lanowink	20c. Location - City of	Town State			
ø o 🗕 노		20a. Method of Disposition  ✓ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec	PARKYINE	MARVIANC							
permit. Page Department Important: finglary of once.		21. Signature of Funeral Service Lice	endee	5	2. Name and Address of Facility AND FUNKALE	JOHO PACK	SEMATION SEL	- 4			
Physician /Medical Examiner but sicien and but sicien and the prijal-transit sthe prijal-transit	sal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  Due to (or as	a consequence of):  a consequence of):  a consequence of):	eR			1 year			
e death certif the ettending hed for use ex	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 m/onths? 1 □ Yes 2 1 Mo 9 □ Unknown	23c. If yes, outcome	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of d Month	elivery Day Year			
res that th signed by I	by Ph	Part II. Other significant conditions  DIAISETES	contributing to death b	ut not resulting in the u	inderlying cause given in Part		tobacco use contribute	to the cause of death?			
law requir es been si 2 should	Completed by					24a. Wa	s an 24b. Were prior to death'	autopsy findings availal completion of cause of			
The law sete hes page 2	5					per 1□ Yes	formed? death 2 No 1 ☐ Ye	s 2 No			
iclan: T certifice rector, p	Be	25. Was case referred to medical			26. Plac	e of Death (Check only	one)				
ysici is cer direc	ToB	examiner? 1 Tes 2 No	Hospital: 1 _ Inpati	ent 2 ER/Outpatie	nt 3 DOA Other: 4 N	ursing Home 5 Res	sidence 6 Other (Sp	pecity)			
ding Ph h. After th tuneral	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat		y Year) 28b. Time of Injury	of 28c. Injury at Work?  M 1 Yes 2		how injury occurred				
is or Attending Physician: The law requires t s efter deeth. al Director: After this certificate hes been signe ed in by the tuneral director, page 2 should be o	Certification:	3 Suicide 6 Could not 4 Homicide determine	28e. Place of In building, e	jury - At home, farm, st c. (Specity)	reet, factory, office	28f. Location City or To	(Street and Number or own, State)	Aural Route Number,			
To the Hospital or Al within 24 hours effer To the Funeral Direc completely filled in by	Medical (			of examination and/or in	th occurred at the time, date an evestigation, in my opinion, de-						
To the within 2 To the complex	×	29b. Signature and title of certifier	& True	u Lu	29c. License number D447		29d. Date signed (Mo				
10		30. Name and address of person wh		death (Item 23a) (Type	Print) 301 ST	PAul TE	12·11·0	D 21202			
Sta	ate	31. Date filed (Month, Day, Year)		rar's Signature	ale						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** ANTHONY ANDERSON 9:36AM ALUNZO 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HVENUE EdMONDSON BAHDHOLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours 1**%** M 2□F MAKYLAM 214 \$2 0350 Usual Residence of Decedent Director 10d. Inside City Limits 10c. City, Town or Location 28a-f show 1 Nes 2 No BALTINOR must be notified Funeral Director MARYLAND permit. Pages 1 and 2 should be filled within 72 hours after death with the N Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-fany Injury or other traumatic event, the Medical Examiner must be notified once. 10g. Citizen of What Country? 10e. Street and Number U5 A 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: þ 3 Widowed 4 Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 24CANS LESMAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be / sy /02 In DEISON ALPHONSO ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HNOCKSON 2934 HOSHEr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ligen ee RCIS TETS tour LOMO 5240 BAIMMER, Med 21 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiovaccular **Physician** /Medical Due to (or as a consequence of): Examiner edencion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): and Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 ☐ Nursing Home 5 🖫 Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔼 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

X State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Y orla

32. Registrar's Signature

Ballimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Road

DHMH 17 Rev 1/2001

29c. License number

04049

, MD 21212

29d. Date signed (Month, Day, Year)

06

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Akbar Ahmad Abdullah 1- For State Certificate of Death Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 24, 2006 1915 hrs Medical Examiner ABDULLAH AHMAD AKBAR 4b. City. Town, or Location of Death 4c County of Death 4a. Facility Name (if not institution, give street and number) Gaithersburg Montgomery 9116 Edgewood Dr. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. **Funeral** 6. Sex 7, Age (In yrs. last birthday) Months Hours Director 10-29-1951 579-70-0131 1 XM 2 55 Washy., DC Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits Inv 1 🔆 Yes 2 Gaithersburg or 28a-f show Maryland Montgomery Director 10f Zip Code 10g Citizen of What Country 10e. Street and Number USA 9116 Edgewood Drive 20877 or items 23a Funeral 11 Marital Status 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black 1 \*Never Married 2 Married Armed Forces? White, etc. Yes 2 If Yes. Give Year 1 Yes 2 ★ No specify: **Black** Specify: "natural" ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Private Industry Maintenance 12th should be filed within and Mental Hygiene d other t 17. Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Maiden Surname) Gasson D. Bradford Be Izola Bugg 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1930 17th St., S.E. Wash., DC 20020 Katie L. Johnson/sister Department of Health at Important: If item 27 20b Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition tant: If it or other t crematory or other place) Burial 2 ACremation 3 Removal from State Riverdale Park Crem. 12/13/2006 Riverdale, Md. Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cedar Hill FH 4111 PA Ave. Suitland, Md. 20746 Mary Yedgman Part I. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions iner if any, leading to immediate Due to (or as a consequence of) Exami (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last ysician and sician/Medical UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown Ph P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 V Yes ✓ Yes 2 No. 2 25 Was case referred to medical 26 Place of Death (Check only one) Division of Vital Be Other<sub>4</sub> DOA Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 V Other Scene ဥ 1 V Yes No 28a Date of Injury (Month, Day, Year 28c Injury at Work? 28d Describe how injury occurred 27 Manner of Death 28b. Time of Injury Certification: 1 V Natural Yes 2 No 5 Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building etc 3 Suicide Could not be or Town, State) 4 Homicide 29a. Certifier 1

the Hospital or Attending Physician: thin 24 hours after death the Funeral Director: After this certifi

State

Registrar

0

Medical Signature/and title of cer address of person who completed cause of death (Item 23a)

29c License number O.C.M.E

29d Date signed (Month, Day, Year) November 25, 2006

111 Penn Street, Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Laron Locke MD. 31 Date filed (Month, Day, Year) 32 Registrar's Signature DEC 1 2006

and manner stated

Assistant Medical Examiner

ORIGINAL

			State of Maryland / Department of Health and M	•	-	
			1 - State Registrar Certificate of Death		LNO.2005	39652
	s Physici	210	1. Decedent's Name (First, Middle, Last) Evelyn Elizabeth	2. Date of Death Month	Day Year	3. Time of Death
	/Medic			December	5, 2006	8:30 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Lohns Hopkins Bayview  Baltimore		4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		lace (State or Foreign
	Director		215-05-0598 1 M 2 F 89 Yrs. Months Days Hours Min.	May 31,	1917 Cour 1917 M	aryland
	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location		1	Od. Inside City Limits
	Maryli 1 sho	lor	7 1. I			1∭Yes 2 No
	r 28a-	Director	Maryland N/A Baltimore  10e. Street and Number 10f. Zip Code	10g	g. Citizen of What Cour	itry?
	ier death with the Marylar Items 23e or 28e-f show		3559 Shannon Drive 21213		U. S. A	٨.
	lams MITTER	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Year or Dates:		Specify:	White
3	filed within 72 hours after death with the Maryland Hygiene. uthar than "natural", or Itams 23a or 28a-f show ant, If a Medical Evar in arrivest for redified at		15. Decedent's Education 16a. Decedent's Usual Occupation	16	6b. Kind of Business/Inc	
21215-0036	thin 7; e. an "n	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	ng		
	filed wil Hygien othar th	Con	8th Grade Homemaker		Own Home	2
משב	d tal	Be		(First, Middle, Ma	iden Sumame)	
Maryland	should be filed within 72 hours afte nd Mental Hygiene. markad othar than "natural", or I umatic avant, II a Medicul Eraria	To.	Vance Keefer Nora  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura	Metzler	City or Town State Zio	Code)
	and 2 s ealth ar n 27 ls iar trau		Elizabeth N. Barnes (Dghtr) 3559 Shannon Drive, B			1.1
ē,	of Healitem		20a. Method of Disposition 20b. Place of Disposition (Name of		c. Location - City or To	
Ē	Pages nent of I ant: If it ury or o		T CO DUTING 2 CO CONTINUED TO CONTINUE TO	/2006 B	altimore, I	Maryland
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marka any njury or othar traumatic once.		21. Aignature of Funeral Scribe Lio nsee 22. Name and Address of Facility Sch			
_	₫ O = @ Ø		23a Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of			
			shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
ì	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. ARTERIOSCLE police Coudio Vascul  Due to (or as a consequence of):	w Di.	sease	Years
ı	Examiner		D. a. land it and to The	/	tensive	2 2000
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1		1,000
ki	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events c			
760,	ate be executed hysician and he burial-transit	calE				
9	tificate ng phys as the	=				
Box	death certificat e attending phy of for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delive	,
o.	0 0 0	Physician/Med	in the past 12 months?  1		Month	Day Year
٦.	that that and by detac	/Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	e cause of death?
ecords,	The law requires that the ste has been signed by the bage 2 should be detache	d by	DZMZNT/A	1 ☐ Yes	2 No 3 Prob	ably 4 □Unknown
OS S	s bee	Completed	Diabetes Mellitus	24a. Was an	24b. Were auto	osy findings available
r	sician: The law certificate has b irector, page 2 s	mo		autopsy performe 1 Yes 2	d? death?	npletion of cause of 2□ No
Vital	cian: ertific	Be (	25. Was case referred to medical examiner?	<u> </u>		
0		- To			e 6 □Other (Specify	)
O	al or Attanding Phy s after death. il Diractor: After this id in by the funeral of	tlon	27. Manner of Death  1. 12 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?  1 yes 2 No	28d. Describe how	injury occurred	
DIVISION	Attan r deal sctor: by the	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stree	et and Number or Rura	l Route Number,
ā	spital or ours afte naral Dira	Certification:	4 Homicide building, etc. (Specify)	City or Town, S	stat <i>e)</i>	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier (Check only (Ch	and due to the caus	se(s) and manner as st	ated. the cause(s)
	To tha Hosl within 24 ho To tha Funs completely f	Med	one) and manner stated.  29b. Signature and title of certifier 29c. License number		. Date signed (Month,	
	Will To To	_	D1495	9	12/8/04	-wy, 10u1)
	,/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1	/ 0/ 00	
	5		FELIX TAN M.D 4000 EXDMAN NE.	BALTINGI	(E) HD	21213
J	≝ Sta		31. Date filed (Month, Day, Year)  32. Stagistrar's Signature			
	Registr	ar	BEATA 5000 Digites by, When			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death December **Physician** 9, 2006ª 10:30 ам William John Brown /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford 3180 Hidden Ridge Terrace Abingdon If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours | Min. | (Month Day Year April 21) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Pennsylvania **Funeral** 1 ☐ M 2 ☐ F 73 Yrs. 382-30-1719 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "nature!", or items 23a or 28e-f show Abingdon Harford 1 □ Yes 2 No Md. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21009 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a eny nitury or other treumetic event, Ite Medical Examiliant until 3180 Hidden Ridge Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 20XNo Specify: Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) director of contracts legal 5+ attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mae Malloy John Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a, Informant's Name/Relationship (Type, Print) 3180 Hidden Ridge Terrace, Abingdon, Md. 21009 Ruth E. Brown/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/12/2006 Bayview Crematory Baltimore, Md. ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 2/1 auce 610 W. MacPhail Road, Bel Air, Md. 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASYSTOLL /Medical Due to (or as a consequence of) **Examiner** with Severe Hyproxaemia Emphysema

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Rulmonan attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown n signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy performed certificate 1 ☐ Yes 2 XNo Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ို 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) After the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 00184 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fallston MD Harfind MD. 1908 EKH 31. Date filed (Month, Day, Year) 32. Registar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 7, 2006 **Physician** Lamona K. Burdusi 7:35 рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Center Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2□F Months Days Hours 78 197-22-3246 Pennsylvania June 26, 1928 Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10b. County 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Bel Air Md. Harford 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21014 U.S.A. 12 Colonial Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1□Yes Ž□No Baltimore, Maryland 21215-0036 Specify. Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Manatone. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) hospital 12 years medical records clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Kootsouradis Stamatia Kritis ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Father Manuel Burdusi 12 Colonial Road, Bel Air, Md. 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 12/11/06 Baltimore, Md. 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 21. Signeture of Funeral Service Licensee 610 W. MacPhail Road, Bel Air, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician catimo weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the house. resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Ves 2 No r 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending investigation fall MAKNOUW 1 🗌 Yes 2 1 No 2 Accident UNKNOWN 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Colonial Rund, Belfir, mo 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number December 8, 2006 · mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 St Balto. Md Zizox BMC 6781 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

### 06-09150 Elijah Cozart

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

,	1- For State Certificate of Death Reg. No. 2006 3065
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)  ELIJAH S. COZART  2. Date of Death Month Day Year December 1, 2006  1614 hrs
-	4a. Facility Name (if not institution, give street and number)  Good Samaritan Hospital  4b. City, Town, or Location of Death  Baltimore
Funeral Director	5. Social Security Number 212-67-6179
Maryland 28a-f show any d at once. ector	Usual Residence of Decedent  10a. State
the Maryland a or 28a-f sho ntified at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA USA
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene int: If item 27 is marked other than "natural", or items 23a or 28a-f. sho in other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	3 Widowed 4 Divorced of Pear or Dates: 1 Yes 2 X No specify: Specify:
5-0036 ed within 72 hours lygiene other than "natur the Medical Exam Completed 1	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  Never Worked  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Never Worked
ID 21215-0036 should be filed within 7 and Mental Hygiene 77 is marked other than natic event, the Medical To Be Compile	Kevin Cozart Marsha Hutchinson
shou and N	19a Informant's Name/Relationship (Type, Print) Marsha Cozart-mother  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21214  5506 Carter Avenue-Baltimore, Maryland
	20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place) Maple Cremetery  20c. Location - City or Town, State Kew Gardens, New York  21. Signature of Funeral Service Licensee
	21. Signature of Funeral Service Licensee  22. Name and Address of Facility EVANS FUNERAL CHAPEL Parkville, MD 21. Signature of Funeral Service Licensee  22. Name and Address of Facility EVANS FUNERAL CHAPEL Parkville, MD 21. Sagnature of Funeral Service Licensee  22. Name and Address of Facility EVANS FUNERAL CHAPEL Parkville, MD 21. Sagnature of Funeral Service Licensee  Approximate Interval  23a. Part I. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interval
Physician /Medical Examiner	failure List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Death  Between Onset and Death  Death
Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ciscass or injury that mittated events resulting in death). Last Due to (or as a consequence of).
execution and in an an an an an an an an an an an an an	
box 68760, the death certificate beythe attending physic ched for use as the bur Physician/Mec	123h Was decedent pregnant in the 1
P.O. B es that the d gigned by the oe detached	1 Yes 2 ✓ No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box 68' tall or steeding Physician: The law requires that the death certifiers after death  al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as errification: To Be Completed by Physician	24a. Was an autopsy findings available prior to completion of cause of death?  1 V Yes 2 No 1 Yes 2 No
tal F cian: certifi ector,	25 Was case referred to medical examiner? So Place of Dearn (Check only one)
un of Vital  Iding Physician:  After this certif  e funeral director.  To Be (	1 Ves 2 No line in Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other  27 Manner of Death 28e Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred
Division o To the Hospital or Attending within 24 hours after death To the Funeral Director: Aft completely filled in by the fune edical Certification:	Accident Investigation  Accident Investigation Suicide Could not be determined Homicide Investigation Suicide Investigation Suicide Gould not be determined Investigation Suicide Gould not be determined (Specify) Local Street S
To the Hosp within 24 hor to the Fund completely filedical C	
E % E S	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  December 2, 2006
3	30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registra	115 ( ) 3 / (((()))   170 x C x x x x x x x x x x x x x x x x x

			State of Mary				Mental Hyg	iene	
			State     Registrar	Cer	tificate of L	Death		eg. N62 0 0	39656
K	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  OLIVE MARIE CAMPBELL				2. Date of Deat Month Decembe	Day Yes	3. Time of Death  5:30 p M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat	1	4c. County of D	
		_	Mariner Health Care of Laure		Laurel	If Under 24 Hrs.	8. Date of Birth		George's
ľ	Funeral Director		216-22-1448 <sup>1 M 2</sup> XX 80	yrs. last birthday) Yrs.	Months Days	Hours Min.	Month, Day, Dec 1,	Year) 1926 N	Birthplace (State or Foreign Country) laryland
	land ow		Usual Residence of Decedent         10a. State         10b. County         10	c. City, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh	tor	MD Howard	Laurel					1 ☐ Yes 2 No
	th the or 28% e not	Director	10e. Street and Number		10f. Zip Code		10	0g. Citizen of What	Country?
	ath wi		9221 Whiskey Bottom Road		20723-			U.S.A.	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married ② Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Evel Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of Hi f Yes, specify Cuba I □ Yes 2🛛 No	spanic Origin? (S in, Mexican, Puer Specify:	pecify Yes or No- to Ricen, etc.)		merican Indian, /hite, etc. White
9	2 hour atural	ted	15. Decedent's Education	16a. Deced	lent's Usual Occupa	ation	(de a	16b. Kind of Busine	ss/Industry
21215-0036	within 7; ene. than "n he Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  Grade 7		kind of work done of DO NOT use retired maker	lunng most of wo.  )	rking	Own Home	2
197	other	Be Co	17. Father's Name (First, Middle, Last)				ne (First, Middle, M	Maiden Surname)	
Maryland	ould be Menta arked aric ev	ToB	Ernest Latleif			Susie V	Valker		
Jan	2 sho		19a. Informant's Name/Relationship (Type. Print)	111	•			; City or Town, Stat	
e,	1 and Health em 27		John Abner Campbell/spouse  20a. Method of Disposition	20b. Place of Dispo	Whiskey			20c. Location - City	rland 20723
altimore,	Pages ent of nt: If it ry or c		<b>XX</b> Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other ( <i>Specify</i> )		matory or other plac Cemetery		/12/2006	Savage,	Maryland
Balti	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau		21. Signature of Euneral Service Licensee	33	Name and Address Onaldson 13 Talbot			A. , Marylar	nd 20707
Ĭ,			23a. Part1. Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent	er the mode of dyin	g, such as cardia	o or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Cancer of	of Pancre	as with m	netastas:	Ls		Onset and Death 6 months
	/Medical Examiner		resulting in death)  Due to (or as a co	onsequence of):					
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	onsequence of):					
- 1	ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a co	onsequence of):					
8760,	s be ex sician s buria	dical E	d						
9	tificate ig phy as the	ledic							
Вох	ath cer tendin or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 ☐ Live birth 2 ☐	Fetal death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
0	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 XXXo 9 ☐ Unknown 9 ☐ Unknown	e of <b>d</b> eath 5 ☐	Other (specify)			Workin	bay rear
S, P	s that ned by	by Ph	Part II. Other significant conditions contributing to death but no	ot resulting in the ur	nderlyi <b>n</b> g cause <b>g</b> ive	en in Part I.	23e. Did tob	pacco use contribut	e to the cause of death?
ord	w require been sig should b	ted t					1 🗆 Ye	es 2 No 3	Probably 4XX0nknown
or Vital Record	e law r has be je 2 sh	Completed					24a. Was a autops perforr	sy prior	autopsy findings evailable to completion of cause of
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Ħ.	yslcian: is certific director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2XXNo Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatien	nt 3 DOA Othe		ath <i>(Check only on</i> Home 5 ☐ Beside	e) ence 6 ∐Other <i>(S</i>	Specify)
0	Attending Physician: r death. ector: After this certific by the funeral director,	H- 1	27. Manner of Death 1 X Natural 5 ☐ Pending (Month, Day Ye	28b. Time of				ow injury occurred	pesny
Sio	tendli leath. tor: Ai the fu	catic	2 Accident investigation	Athense forms to	M 1 🗆	Yes 2 □ No	00/ 1 11 /01		
Division	al or At s after d al Direc	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury building, etc. (8	- At nome, farm, str Specify)	eet, factory, office		City or Town		r Rurel Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (	29a. Certifier (Check only one)  **Certifying Physician: To the best of more and manner stated and manner stated to the control of the basis of example in the basis of exampl	amination and/or in					
	vithir To th	Me	29b. Signature and title of certifier	. \	29c. License	e number	2	9d. Date signed (M	onth, Day, Year)
			1 400 0	NI	D 24	1721		December	11, 2006
	12		30. Name and address of person who completed cause of death Syed Sadiq, M.D. 14333 Lau.	Dorri	Dood T	aurel, M	arvland	20708	
	Sta	ite	31 Date filed (Month, Day, Year) 32 Registrar's	Signature In	ede La				
	Regist		NEC 1 3 2006 Desure	No Miles					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician**  $a^{\,M}$ 3:50 John A. Crook 0.8 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Hospital Montgomery
9. Birthplace (State or Foreign Rockville If Under 1 Year Months Days If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days **Funeral** Hours Min. **★**|XM 2 | F 63 378-42-0776 Illinois Director 04/06/1943 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show MD TX Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified, once. Montgomery Director Rockville 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 5904 Crawford Dr. 20851 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: white à 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government 4 Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jack Crook Florence Weiss ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 8 7 6 19a, Informant's Name/Relationship (Type, Print) Barbara Crook/wife 19125 Staley Bridge Rd. Germantown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of FacilitySilver Spring, MD 20910 21. Signature of Funeral Service Licensee 201358 Rapp Funeral&Cremation Svc933 Gist Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PSIS weck **Physician** 50 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use as t attending p IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe , 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 200020 24a. Was an page 2 s autopsy performe 1☐ Yes 2 1 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 3 DOA 2 ER/Outpatient Certification: To After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation within 24 hours after co...

To the Funeral Director: Aft М 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Research BLVD Suite 330 Rockuste 2401 (gaste)

D38262

	•	1 = For State Registrar	State of Maryl		artment of tificate of		-	giene Reg. No.2006	39658
Physicia		1. Decedent's Name (First, Middle, Las.	DECARL	-0			2. Date of De	ath Spay Ook	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of D	eath	4c. County of Dea	th
		Howard County Gene	eral Hospita	1	Columb			Howard	
Funeral Director			7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days		Min. (Month, Da	th Ly, Year) 9. Bir Co 4, 1928 Was	thplace (State or Foreign cuntry) hington, DC
aryland show	J.	Usual Residence of Decedent  10a. State 10b. County  Maryland Worcest		. City, Town or Lo					10d. Inside City Limits 1√2√Yes 2 □ No
Ne M	Directo	10e. Street and Number	er		10f. Zip Code			10g. Citizen of What Co	
with	늅	706 S. Surf Road			2184	12		U.S.A.	outiny :
leath ms 23	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13. V			? (Specify Yes or No uerto Rican, etc.)		encan Indian,
paritimity of the parity of the control of the control of the parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydinea. Hydinea important: If the m27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic svant, the Medical Examinar must be notified an once.	þ	1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1XXYes 2 □ No If Yes, Give Year or Dates: —	1951	f Yes, specify Cu 1 ☐ Yes 21000000		uerto Rican, etc.)		e, etc. Nite
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Janua Jid be file Jental Hy rked oth tic svant	To Be (	17. Father's Name (First, Middle, Last) Nicolangelo DeCarl	Lo				Name (First, Middle La Lunard	•	
rvially  1d 2 shou  Ith and h  27 is ma		19a. Informant's Name/Relationship (7 Marie D. Welsh /	ype, Print) sister		ng Address (Stree		_	er, City or Town, State, el, Marylan	
s 1 ar f Hea litem othe		20a. Method of Disposition		b. Place of Dispo	sition (Name of natory or other pl	(ace)	Date	20c. Location - City or	Town, State
Page Hent o Int: If		1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Gate of			/12/2006	Silver Spr	ing, MD
permit. Depertmine imports any injuice.		21. Signature of Euneral Service Licens		0.7.70			al Home, nue Laur	P.A. el, Marylan	d 20707
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Si Si €	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	isequence or).					
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	livery Day Year						
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or Atten after deat Director: in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str pecify)				Street and Number or R wn, State)	ural Route Number,
To the Hospital or Attending To the Hospital state death. To the Funeral Director: Alter completely filled in by the fune	edical C	29a. Certifier (Check only one)	/sician: To the best of my iner: On the basis of examination and manner stated.	knowledge, death nination and/or in	n occurred at the vestigation, in my	time, date and p opinion, death o	place, and due to the occurred at the time,	cause(s) and manner at date and place, and due	s stated.  to the cause(s)
To the within To the	Me	29b. Signature and title of certifier	111		29c. Licer	nse number		29d. Date signed (Mont	ከ, Day, Year)
		> KNAPECY	WY		0,5	5181		Dec/f	2006
2011		30. Name and address of person who o	completed cause of death	(Item 23a) (Type,	Print)	NETT	t GET	1) 2(20)	
Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's S	ignature	13/7 L	- 11 mo	The R		
Registr		DEC 13 20	106 Bear	J. 190	342				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For State Amend item#10f, perFH, C862, 12/13/06 Trifficate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician EDWARDS 11:00 AM December 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FOHNS HOPKINS HOSPITAL BALTIMORE N Ci If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2**X**F 215.24.9706 09/27/1926 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show Examiner must be notified at Baltimore 1 Yes 2 No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 915 Abbott Court USA "natural", or items 23a 21202 Funeral within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐ Yes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married 2 No Black 1 ☐ Yes 2 XNo Saltimore, Maryland 21215-0036 Specify: 2 If Yes, Give Year or Dates: Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " College (1-4or 5+) Elementary/Secondary (0-12) Domestic Homemaker Tharade permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygis Important: If item 27 is marked other injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Steward Minnie Greene 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 903 North Hill Road Baltimore MD 21218 Sladell Callonay / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State Baltimore, MD Mt. Zion Cemetery 1213/06 4 □ Donation 5 □ Other (Specify) 22 Name and Addr. of Facility Vallahus C. Greene Funeful Services 4905 York Road Balfimore MD 21212 21. Signature of Funeral Service Licensee m01363 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. SEPSIS Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner FROM DIVERTICULITIS ACUTE ABDOMEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine for use as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician pe Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the aid Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 30 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred after death. I Director; After the 28c. Injury at Work? al or Attending Fafter death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) RES-000 completed cause of death (Item 23a) (Type

State

DHMH 17 Rev 1/2001

Registrar

2006

Street Baltimore Manyland North Wolfe

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 09,2006 **Physician** 23:43 ™ Louise Mary Etchison Dec /Medical 4c. County of Death 4b. Cify. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 5404 Belair Road Angels Cove Birthplace (State or Foreign Country) Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔽 F Hours 217.18.1316 Marvland Director 09.27.1923 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State a or 28a-f show t be notified at 1 ☐ Yes 2 ☐ No Director Edgewood MD Harford death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S,A. 21040 must b 128 Red Bud Road Funeral 14. Race - American Indian, ral", or items 2 Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after of nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or itea any or other traumatic event, the Medical Examines. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth A. Tuder William Edward MacKenzie ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 128 Red Bud Road, Edgewood, MD 21040 Jean Chelton/daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, MD 12.12.06 Chesapeak Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Cremation And FuneralBalt. Alternatives 8717 GreenPastures Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION one hour Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION Completed ABPOMINAL ADRIC ANEURYSM 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 27 No this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

or Attending Physician: The law requires that the death certificate be executed after death.

Director: / within 24 hours a To the Funeral I completely filled

Certification: To Medical

DECEMBER 11 2006

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

ss of person who completed cause of death (Item 23a) (Type, Print)

MD

BAUTIMORE, MAKYLAND 21287

ZES-000

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a, Certifier

ALMA AHOONKHAI GOO NORTH WOLFE STREET 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene UUD

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12-10-2006 **Physician** Aubrey Jackson Foster 11:05A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Manor Care-Ruxton Towson Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days **Funeral** 1**M**M 2□ F 219-28-4787 75 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Baltimore Towson Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1805 Roland Ave. 21204 Items 23a USA Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give WWII Year or Dates! 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify: White Maryland 21215-0036 "natural", or 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pagas 1 and 2 should ba filed within ment of Health and Mantal Hygiene. ant; If Item 27 is marked other than ury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Mason 8 Self Employed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Andrew Jackson Foster Edith Mae Woodward Foster Cave 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rick Hyde- Son-in-law 3415 Augusta RD. Manchester, MD 21102 Baltimore, Ob. Place of Disposition (Name of Derivern cayator a trip(&/199) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Paga Department of Important; If eny injury or Memorial Gardens 12-14-06 TIMONIUM, MD 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licensee Center 2325 York Rd. Timonium, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chroni Years **Physician** Severe /Medical Due to (or as a consequence of): Examiner monar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Examiner The law raquires that the death cartificate ba axecutad burial-transit and Due to (or as a consequence of): Box 68760. th, IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day Po in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signad t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed? Yes 22 No page 2 certificata has 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check onl. one Other: Hospital: 1 ☐ Yes 2 No 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide hours after within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 0-0012849 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DY. TOWSON MD 21204 CHILADI. 1600 Day, Year) 31. Date filed (Month. State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month .40 P M OWARD 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death FRanklin 5. Social Security Number Square 6. Sex Hoseda HIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 108 M 2□ F 1ARYLA OC 3-30-3202 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Yes 2 No CALTIMORE MARIANI 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code ROAD 21178 0833 12. Was Decedent Ever in U.S. Armed Forces?

↑☆ Yes 2 ☐ No If Yes, Give Year or Dates: ₩ . ₩ . ₩ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Marned Specify: WHITE 1 ☐ Yes ≥ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) NISTERN NEINIES R 59 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) CARWOZ LARA IZIKI LIVOL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) PHYLL'S JIAN FRANK 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12 ととろいているとのよとかのころ 3008 22. Name and Address of Facility. HARLANDERS MATTOR
EVANTE SERVICE ROPE FARKING MARKET SIRVIES 21, Signature of Funeral Service Licenser MARYLAND ADOM YOU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Devere Due to (or as a consequence of): entic em Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) C Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 ⊠Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 20 No 1 Tyes 1 Yes 26. Place of Death (Check only one) Hospital:

/Medical Examiner Examiner physicien and s the burial-transit Completed by Physician/Medical as the attending for use as signed by the a should I page 2 s

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

**Funeral** 

Director

item 27 is marked other than "natural", or lisme 23s or 28s-f show other treumstic event. The Medical Examinar must be notified at

I Hygiene.

Pages 1 and 2 should be file ment of Health and Mental Hi lent: If item 27 is marked oth

permit.

ŏ Department of Importent: If eny injury or once.

**Physician** 

the Maryland

21215-0036

Maryland

more,

Box 68760, <

P.0.

Records,

Division of Vital

Hospital or Attending

death.

1

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Hinknown

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

5 Pending investigation 6 Could not be determined

1 Thipatient 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Matural

2 Accident

3 Suicide

4 - Homicide

1 🚅 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ardale

29c. License number

Sq. dR.

Baltimore

29d. Date signed (Month, Day, Year) -10-06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 AR Alikeza

State Registrar

Be

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Certification:

Medical

director

Pis After this

Director: /

To the ...
within 24 hours ...
To the Funeral Director.

31. Date filed (Month, Day, Year) DEC 1 3 2006



Franklin

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day December 11, Physician RITA O'DONNELL 2006 4:30 a M /Medical 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens @ Riderwood Silver Spring Prince George's 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 □ F 577-26-5882 Yrs 89 Director Sept PA 6, Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10b County 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, Ina Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD Prince George's Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3160 Gracefield Road 20904 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☒ No If Yes, Give Year or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ № Specify: à Specify: 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filad within 72 th and Mental Hygiene. 7 Is marked other than "nu Elementary/Secondary (0-12) College (1-4or 5+) 3 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cornelius O'Donnell Margaret McCall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pagas 1 and 2 s ment of Health an ant: If Item 27 Is I ury or other traus Janet Marie Frost Hannan 5916 Indian Summer Drive Clarksville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Purial 2 □ Cremation 3 □ Removal from State permit. Page Department Important: If any injury or Ft. Lincoln Cemetery | 12/14/2006 | Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, of shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pnly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebrovascular Accident Days /Medical Due to (or as a consequence of): Examiner Athersclerotic Cardiovasular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physiclan/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XXo Day Year 4 □ Pregnant at time of death 5 Other (specify) P.0. the detached 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 99 Atrial Fibrillation 1 Yes 2 No 3 Probably 4 XXnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a Wasan autopsy Aortic Valva Prosthesis deain: 1 ☐ Yes 2 [X][X]o Division of Vital 1 ☐ Yes 2 **X X** o Physician: Be 25. Was case referred to medical 26. Place of Death Check onl one Hospital: Other: 1 ☐ Yes 2 💢 💢 o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ဂ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After Hospital or Attending 1 XX Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29b. Signature ar d title of o 29c. License number 29d. Date signed (Month, Day, Year) D 24035 Dec. 11, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E.S. Machado, M.D. 3110 Gracefield Road Silver Spring, Maryland 32 Registrar's Signature State Registrar

			Plea	se Type or					-		egible.			
		For State Registrar		State	of Marylar		urtment of H Stificate of		Mental H	/giene Reg. No.	2006	20661		
		1. Decedent's Name (	First, Middle	e, Last)			imouto or		2. Date of D	eath		3. Time of Death		
Physi /Me		1// 1// 1	rt	K	enneth	Gi1	lispie		Decem	ber 7	, 2006	2:25РМ м		
Exam	nine	4a. Facility Name (If no Southern					4b. City, Town, o	Clintor			4c. County of Death Prince George's			
Funera		5. Social Security Num 233-30-749		6. Sex 1 X M 2 ☐ F	7. Age (In yrs. 83	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mii	irth 20, Year) 20, 192	Year) 9. Birthplace (State or Foreign Country), 1923 West Virginia				
and w		Usual Residence of De	ecedent 0b. County		10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits		
Maryla -f sho fled at	1			e George'	S	Temp	le Hills					1 ∐Yes 2 📆 No		
th the or 28a e notti	of control of the con	10e. Street and Number	er				10f. Zip Code			10g. Citiz	en of What Coun	try?		
ath wi 23a ust b	-	3805 Hemlo	ock Pi					20748			U.S.A.			
ter de		11. Marital Status 1 □ Never Married	2X Marr	Armed F	cedent Ever in U Forces? s 2  No	I.S.   13. \	Was Decedent of F f Yes, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	lo- 1	<ol> <li>Race - Americ Black, White,</li> </ol>			
urs af al', or Exami	Š	3 □ Widowed 4 [		If Yes, C Year or	Bive		I□Yes 2☑No	Specify:		;	Specify: Wh	ite		
72 ho 72 ho 'natur	100	(Specify	5. Deceden	t's Education st grade completed	1)	16a. Deced	lent's Usual Occup kind of work done OO NOT use retire	oation during most of w	rorking	16b. Kin	d of Business/Ind	dustry		
within ene.	Completed	Elementary/Second		College	(1-4or 5+)		tract Of	•		DO	OD			
ifiled Hygi other	2	17. Father's Name (Fit	rst, Middle,			1 001	tract or		ame (First, Middi		Surname)			
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partitionity, Intal yitaing AILINGOOD  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name Doris S. (			e)	1	g Address (Street Hemlock					/		
of Her		20a. Method of Dispos		3 □Removal from	n State	Place of Dispo cemetery, crer	sition (Name of natory or other pla	ce) De	ec. 16,	1	ation - City or To	•		
mit. Pages partment of portant: If It		4 □ Donation 5	Other (S	pecify)	Arbe		emetery		006	1	ovale, W			
Delmit Depar Impor any In	ouce.	21. Signature of Fune	ral Service	Licerisée	maraco		Name and Addre		Lee Fune			n ,MD20735		
		23a. Part 1. Enter the	disease, or	complications that only one cause on	t caused the dea						OTTHEO	Approximate		
Physicia /Medica	_	Immediate Cause (Fir disease or condition resulting in death)		_a A	o (or as a consec	Tuence off: Y	0 C DV	diaL	INF	216	Tron	Interval Between Onset and Death		
Examine	1	Sequentially list condi	tions	b. C	OILON	347	HILL	cvy	DIS	2 5	i			
ed		Sequentially list condi it any, leading to imme cause. Enter Underlyi Cause (Disease or inju-	ediate ing -	Due to	o (ur as a conset	quanca of).l		/	,					
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rtificate ng phys	100	IF FEMALE:		1			-							
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  When the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	l'acicio:	IF FEMALE: 23b. Was decedent print the past 12 mm 1	onths?	1 ☐ Live	outcome pf pregn e birth 2□Feta gnant at time of e known	al death 3	Ectopic pregnanc Other <i>(sp</i> ec <i>ify)</i>	у		23	3d. Date of delive Month	ery Day Year		
s that		Part II. Other significa	ant conditi	ons contributing to	death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco us	se contribute to th	ne cause of death?		
equire equire en sig ould b	3	HNEXI		Enci	tha Lo	150	L, 7		_ 1 [	Yes 2	No 3 ☐ Prob	ably 4 Unknown		
he law requires to has been signed go 2 should be o	1 2 2	Diahel ATrie	tes.	Mell	· Tus				24a. Wa aut	opsy	24b. Were auto prior to cor	psy findings available mpletion of cause of		
al n r: The ficate l ficate l			4	F. 500	112710	2 17			1□ Yes		death? 1 ☐ Yes	2 🗖 No		
VICAL rslcian: 7 s certificat lirector, pa	6	25. Was case referred examiner? 1 ☑ Yes 2 ☐ No		Hospital:	Inpatient 2	] ER/Outpatien	t 3 DOA Oth	or:	eath <i>(Check only</i> Home 5 Re		Other (Specific	v)		
tending Phy eath. tor: After this	100		5 ☐ Pendir investi	28a. Dat	te of Injury onth, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at	28d. Describe			<i>n</i>		
I ON Atten after deat Director	o di di di di di di di di di di di di di	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ	not be 28e. Pla	ce of injury - At h Iding, etc. (Speci	iome, farm, str ify)	eet, factory, office		28f. Location City or To	(Street and own, State)	Number or Rura	l Route Number,		
e Hospita 24 hours e Funeral letely filled		29a. Certifier 1		ng Physician: To t Examiner: On the and ma										
To th within To th	1	29b. Signature and titl	e of certifie	r			29c. Licens			29d. Date	signed (Month,	Day, Year)		
}		1	To Te	11.	ND		DI	98 5	9	De	c · 8 -	06		
1		30. Name and addres	s of person	who completed ca	use of death (Ite	m 23a) (Type,	Print)							

State

Registrar

		1 - For State Registrar	State of M	larylar		artmen rtificate			and M	-	giene Reg. No.	2.0.0 8	396	565
sicia	ın	1. Decedent's Name (First, Middle, La.		212MI2						2. Date of De Month Decemb	ath Day	, 2006	3. Time of	
edica	al -	NARCISSA MAT  4a. Facility Name (If not institution, giv.		SENE		4h Cihi	Tour or l	Lagation	of Dooth	Decem		County of De		рм
ımine	er	Laurel Regional F		,			Town, or I urel	Location	Deam				George':	S
ral		5. Social Security Number 6. S	ex 7. A	ge (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	th			
tor		218-16-8666	□M 2□F	83	Yrs.	Months	Days	Hours	Min.	July 22	19	23 M	rthplace (State of Country) [aryland	
	-	Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation	<del></del>						10d. Inside Ci	ity Limits
	ច	Virginia Warren			inden								1 ₩ ¥es	
	rect	10e. Street and Number				10f. Zip	Code				10a, Citiz	zen of What C		
		1351 Khyber Pass	Road				2264	12		į	U.S		,	
	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U	.S. 13.	Was Deced	lent of His	panic Ori	gin? (Spe	cify Yes or No Rican, etc.)	)- 1		erican Indian,	
		1 Never Married 2 Married	1 ☐ Yes 2√7	No		1		Specify:	i, rueito i	rican, etc.)		Black, Wh Specify:		
	b b	XXWidowed 4 □ Divorced	If Yes, Give Year or Dates										White	
	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced	dent's Usua kind of wor DO NOT us	il Occupat rk done du se retired)	tion <i>uring</i> most	t of workir	g		nd of Busines	•	
	E	Elementary/Secondary (0-12)	College (1-4or 1 Year	5+)		ountar						arch & lopmen		
	BeC	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle				
ľ	To B	Charles Clayton I	Davis					Myrt	:le V	irgini	a Ste	erling		
ľ		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address	(Street ar	nd Numbe	r or Rura	Route Numb	er, City or	Town, State,	Zip Code)	
l		Charles R. Greene	e / son		Assessment of the Contract of			ass R		Linder	ı, Vi	rginia	22642	
l		20a. Method of Disposition 1 ☑ Kurial 2 ☐ Cremation 3 ☐	Removal from State		Place of Dispo cemetery, crer	natory or of	ther place			ate .		cation - City o		
l		4 □Donation 5 □ Other (Specific	r)	Ft	. Linco							entwood	, MD	
		21. Signature of Funeral Service Licer	1599	/ 240	01.60	Name and Dona I	d Address	Fune	ral	Home, I	P.A.	_		
	-	232. Pakt. Enter the disease, or com	reacon							Laure		larylan	Approximate	
	Examiner	shock, or heart lailure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Multi Due to (or a  Respi: Due to (or a	Orga saconsed rator saconsed Vent	y Failu wence of). ricula:	ure	hycar	rdia					Interval Bett Onset and I	
	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	d	2 Feta	ildeath 3□	Ectopic pre					2	3d. Date of de Month	,	/ear
١.	۾	Part II. Other significant conditions of Chronic Obstruct:					au <i>s</i> e giver	n in Part I.			obaccous Yes 2∫∑		to the cause of d	
	Completed									24a. Was autor perfo 1 🗆 Yes		24b. Were a prior to death?		available ause of
10	Be	25. Was case referred to medical examiner?	Hospital:			-			of Death	Check only o	ne)			
1	2	1 ☐ Yes 2/€No 27. Manner ol Death	Hospital:		ER/Outpatien 28b. Time of			4 🗀 Nui		e 5□Resid			ecify)	
	Certification:	1XXIatural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			Injury	М		es 2 🗆 N	No	8d. Describe I				
		4 Homicide determined	28e. Place of In building, e	tc. (Specif	(y)					City or Tov	vn, State)		lural Route Numi	ber,
	edicai	29a. Certifier 1 A certifying Ph (Check only one) 2 Medical Exam	ysician: To the bes niner: On the basis and manners	ot examina	wledge, death tion and/or inv	n occurred a vestigation,	at the time in my opi	, date and nion, deat	d place, a th occurre	nd due to the d at the time,	cause(s) a date and	and manner a place, and du	s stated. e to the cause(s)	)
13		29b. Signature and title of certifier					License		1				th, Day, Year)	
	- 1		Λ	A 6		-		~ / \	11	) [	A 1	1 m	/	
		1 Ki Shi lat	to r	1 1)		L	)0(	26	4 >	21	12/	10/0	6	
		30. Name and address of person who is SPICATHA IC	completed cause of	death (Item	n 23a) (Type,									0707

# ■ Baltimore Maryland 21215-0036

				Pleas	se Type or						. Ensure lealth and		•		•	e.	
		•	For State Registrar		State	JI IVIC	ai yiai k		ertifica			ı IVICI		Reg. No.	00	76	30666
W:			Decedent's Nam	ne (First, Middle	, Last)							2.	Date of De	of Death 3. Time of Death			
	Physicia /Medic			Naomi (	Gregory								A	ecenter 7 200 6 2-00 PM			
ě	Examin	er	4a. Facility Name (i			umber)			4b. City		r Location of De t <b>imore</b>	eath		4c.	County of	Death	1
1 2	Funeral		Harborsid  5. Social Security N		6. Sex	7. Age	e (In yrs. la	ast birthda		r 1 Year	If Under 24 H	rs. 8.	Date of Bir (Month, Da	f Birth 9. Birthplace (State or Foreign			
	Director		218-12-36 Usual Residence o		1□M <b>¾</b> □F		8	No. Yrs.	Months	Days	Hours M	ın. C	2/05/1	921			UNK
yland	show ed at		10a. State	10b. County			10c. City	, Town or l	Location								10d. Inside City Limits
e Ma	Ba-f sl	Director	MD								timore						1 <b>X</b> Yes 2 □ No
with th	a or 2 be no		10e. Street and Nu						10f. Zi	p Code	01.00	<i>)</i> .		10g. Citi	izen of Wh	at Cou	-
leath	ns 23 must	Funeral	4700 Harf	ord koad	12. Was De	cedent I	Ever in U.S	S. 13	B. Was Dece	edent of H	21224		/ Yes or No	)-			USA Ican Indian,
2 should be filed within 72 hours after death with the Maryland	l", or iter xaminer	by Fur	1 ☐ Never Man	_	Armed F fed 1 Yes If Yes, G Year or	2 📉 N Sive	2 X No ye 1 ☐ Yes 2 X No Specify:										can American
2 hou	atura ical E	ted	(Sno	15. Decedent	's Education st grade completed	n			edent's Us		eation during most of v	varkina		16b. K	ind of Busi	ness/l	ndustry
ithin 7	ne. nan "r e Med	Completed	Elementary/Seco		College	(1-4or 5	i+)	life	DO NOT	use retire	d)	vorking					
illed w	Hygie ther ti		17. Father's Name	(First, Middle,		NK_				UNK	18. Mother's N	lame (F	irst, Middle	. Maiden	UNK Surname)		
ld be	ental ked o ic eve	To Be		(,	UNK							,	UN		· ·		
d 2 shou	Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified once,		19a. Informant's Name/Relationship (Type. Print)  Alice Bellamy / Guardian  19b. Mailing Address (Street and Number or R 10 N. Calvert Street;														. ,
s 1 and	f Heal item 2 other		20a. Method of Dis				20b. P	lace of Dis	position (Na rematory or	ame of	ce)	Date	)	20c. Lc	ocation - Ci	ty or	Town, State
Pages	nent o			$\square$ Cremation 5 $\square$ Other ( $S_i$	3 □Removal fron pecify)	n State		· ·	n Ceme			14/20	06	Balt	imore,	Man	ryland
ermit.	Departr Importa any inj once,		21. Signature of Funeral Service Ocensee 22. Name and Address of Facility Wylie Fun											,			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										Maryia	IIG	21217 Approximate		
Pi	nysician		shock, or hea	art failure. List (Final	only one cause on	each lir	1e.				_				re		Interval Between Onset and Death
\$ 1	Medical		disease or condition resulting in death)	OII	Due to	o (or as	a consequ	uence of):			over cr		10				
E)	xaminer	_	Sequentially list co	onditions,	D		a consequ		ene	nte	ς '						
nted	rnsit	Examiner	Sequentially list co if any, leading to in cause. Enter Undo Cause (Disease of that initiated event	mmediate erlying r injury	2.			mcm									
e exect	an and rial-tra		resulting in death)	Last	C		a consequ										
ate be	hysicie the bu	lical			d												
Sertific	attending physician and for use as the burial-transit	/Mec	IF FEMALE:		23c. If yes, o	utcome	pf pregna	псу							23d. Date	of dali	von.
death	atten d for u	iciar	23b. Was deceder in the past 12 1 Yes 2	2 months?	1 ☐ Live 4 ☐ Pre	birth gnant at	2 ☐ Fetal time of de	death 3	B⊟Ectopic   5 □ Other (s		у				Month		Day Year
at the	signed by the a	Physician/Medica	9 🗆 Unknow	n	9□Unk			ulting in the	unded inc	course di	von in Root I		02a Didd	inhanna i	una contrib	uto to	the cause of death?
quires th	been signer should be d	by	Part II. Other sign	mcant conduc	ons contributing to	deali D	utilotiest	ining in the	underlying	cause giv	reir iii rait i.	_	_	Yes 2			obably 4 Unknown
law re	has bee	Completed							_			_	24a. Was		24b. We	ere au	topsy findings available ompletion of cause of
The	cate h	Соп											perfo 1□ Yes	ormed? 2 □ No	de:	ath? ]Yes	2 No
Sician	certifi	o Be	25. Was case refe examiner? 1 ☐ Yes 2☐		Hospital:	Innetic	ent 10	ED/Outpati	ient 3□□	Oth	26. Place of I				. Do::		~ .
To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		27. Manner of Dea	ath 5 □ Pendin	28a. Dat g (Mc		ry	28b. Time Injury	of /	28c. Inju			5 L. Hesi I. Describe				iry)
Attend	er death rector: , by the f	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investiç 6	not be 28e. Plac		ury - At ho c. <i>(Specif</i> )		M street, facto		Yes 2 □ No	28f.	Location (			or Ru	ral Route Number,
	eral DI		29a. Certifier	1 Cartifula	ng Physician: To the				ath occurre	d at the ti	me date and pl	200 200				301.00	atatad
the Hos	within 24 hours after death.  To the Funeral Director: Completely filled in by the filed in by	Medical	(Check only one)	2 Medical	Examiner: On the and ma		f examina		investigation	on, in my	opinion, death o			date and	d place, an	d due	to the cause(s)
7 10	To Con	Σ	29b. Signature and	d title of certifie	SA	11-			2	ec. Licens	2 o Cu	1		29d. Da	te signed (	Month	1, Day, Year)
•	1		30. Name and add	dress of person	who completed ca	use of d	eath (Item	23а) (Туқ	e, Print)	1)	7004	1		NC (	מוע	W	12 200 6 d MP2/22/
	Sta	to	31. Date med (1800)	min, Day, rour,	rally 3	201 Registr	- 30 <sup>C</sup> ar's Signa	ture	ach	KI	V4 RI	N	· N	ech	K	040	d MASISSI
	Registr				2006	Buc	ar's Signa	1	de								

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo O O C

			For State Registrar	State of Maryla		ertificate of			lienez () () {	5 39667	
	Division		Decedent's Name (First, Middle, Last)			1/ /	/ -	2. Date of Deal	th	3. Time of Death	
	Physici /Medic		EUNICE			HASK	ins	Novem	BL 27,10	06 3.50 AM	
	Examin	er	4a. Facility Name (If not institution, give s	street and number)	1.1.1	4b. City, Town, o	r Location of Deat	h	4c. County of De	eath	
	Euparal		5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday	YUnder 1 Year	MDPC If Under 24 Hrs	8. Date of Birth	of Birth 9. Birthplace (State or Foreign		
	Funeral Director		245-78-1285	M 2 <b>X</b> F 6		Months Days	Hours Min.	8. Date of Birth (Month, Day) AUG 3		NC	
	yland yland		10a. State 10b. County	10c. C	City, Town or I	ocation				10d. Inside City Limits	
	B Mar	Director	MD	В	ALTIMO	RE				1 XYes 2 ☐ No	
	vith th	Dire	10e. Street and Number			10f, Zip Code		1	0g. Citizen of What	Country?	
	eeth ve 23s	erai	1006 N. CASTLE ST	• 12. Was Decedent Ever in	118 12	21205	lianacia Origina / (5	Paneity Van ar Na	USA	nerican Indian,	
036	be filed within 72 hours after deeth with the Maryland ital Hygiene. Id other then "natural", or iteme 23e or 28e-f ehow event, the Medical Examiner must be multified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 XNo If Yes, Give Year or Dates:	0.5.	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗷 No	Specify:	to Rican, etc.)	Black, WI	nite, etc.	
Maryland 21215-0036	72 ho 'natur	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Giv	edent's Usual Occup	during most of wo	rking	16b. Kind of Busines	ss/Industry	
121	within 72 8ne. then "nat	mpi	Elementary/Secondary (0-12) 1 2TH	College (1-4or 5+)		DO NOT use retired	d) -		HOME		
<u>0</u>	Hygid other	0	17. Father's Name (First, Middle, Last)		по	MEMAKER	18. Mother's Nar	me (First, Middle, I	HOME Maiden Sumame)		
<u>la</u>	should be ad Mental marked c	To B	BEN WIGGINS				MINNIE	E BEST			
a D	2 should and Men ie marke sumatic	V 1	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. <b>M</b> ai	ling Address (Street	and Number or Ru	ıral Route Number	, City or Town, State	, Zip Code)	
	s 1 and 2 should f Health and Mer Item 27 ie marke other traumatic		KYSHA GRAY/DAUGHT			06 KENYON osition (Name of	AVE., BA	LTIMORE,			
5	00		20apMethod of Disposition 1 ⊠Burial 2 □ Cremation 3 □ R	emoval from State	cemetery, cr	ematory or other place	1			INS FERRY RD.	
Baltimore,	permit. Page Department Important: If eny injury or once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License			V CEMETERS 22. Name and Addres			LANSDOWNE VIS, JR. 1		
ñ	Per important		Millestar	March		2007-09	EASTERN	AVE., BA	LTIMORE, I		
			23a. Parit Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the de- e cause on each line.	ath. Do not e	nter the mode of dyin	g, such as cardia	or respiratory arre	est,	Approximate Interval Between	
>	Physician		Immediate Cause (Final disease or condition resulting in death)	HUDOG	LUC	EMIA				Onset and Death	
H	/Medical Examiner		Todaming in doubly	Due to (dr as a conse	quence of):						
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quenca of).						
	nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
60,	ifficate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a conse	quence of):						
68760	ifficate g phys as the	edicai									
Box		M/U	230. Was decedent program	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe		☐Ectopic pregnancy			23d. Date of d	,	
o.	The law requires that the death cer sie has been signed by the attendin page 2 should be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown		Other (specify)			Month	Day Year	
S, P.	s that gned b		Part II. Other significant conditions con	tributing to death but not re	sulting in the	underlying cause give	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?	
g	w require been signature	ted	DIABETES	MELLI	TUS			1 🗆 Ye	es 2 No 3 1	Probably 4 Unknown	
Records,	has by	Completed by						24a. Was an autops perform	y prior to	autopsy findings available completion of cause of	
Vital		မိုင်	25. Was case referred to medical			<u> </u>		1 ☐ Yes 2	2□No 1□Ye	95 2 No	
	ysicii is cert direct	To B	examiner?	ospital: 1 ☐ Inpatient 2	ERVOutpatie	ent 3 DOA Othe	0.0	ith <i>Check</i> o <i>nly on</i> lome 5 ☐ Reside	ence 6∐Other <i>(Sp</i>	nacify)	
Division of	ng fler		27. Manner of Death  1 Natūral 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Injury Work			ow injury occurred		
	or Attendi	Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, s	treet, factory, office		28f. Location (St. City or Town	reet and Number or I	Rural Route Number,	
	To the Hoepital or A within 24 hours after To the Funerel Directompletely filled in by		29a. Certifier 1 Certifying Phys	ician: To the best of my kr	nowledge, dea	ith occurred at the tim	ne, date and place	, and due to the ca	ause(s) and manner	as stated.	
	To the H within 24 To the F complete	Medical	one)  29b. Signature and title of certifier	er: On the basis of examinand manner stated.	- Andrews	29c. License				```	
)	5 1 K 2	-	A ( A A A A	no Rana	aN	TIE	50-91-	7	9d. Date signed (Moi	0 = 7 00/	
	$\cap$		30. Name and address of person who co	mpleted cause of death (fre	om 23a) (Type	p. Print)	0/ 11		1	0000	
	C		JULIAUNA JUN 31. Date filed (Month, Day, Year)	32. Registrar's Sign	ON.	NOIFE S	F. BAL	IMOLB. 1	MARY land	21287	
	Sta Registr			006	K	hack .			}		

•	•		For State Registrar	State of Marylan		ment of H		Re	g. No.	6 39668
	Physicia /Medica	al	1. Decedent's Name (First, Middle, Last  Chowlene H  4a. Facility Name (If not institution, give	arley	45	City Town	r Location of Death	2. Date of Death Month DE C	Day Y	3. Time of Death
	Examine Funeral	er	ST AGNES H  5. Social Security Number 6. Se	05 P 1 T AC 7. Age (In yrs.	last birthday) If	Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth	1	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent  10a. State  10b. County	10c. Cit	Yrs.  y, Town or Location			10 097	1959	10d. Inside City Limits
	the Mary	Funeral Director	MD N/A  10e. Street and Number		1	HMOV4	e	10	g. Citizen of Wha	1 <b>⊠</b> Yes 2 □ No at Country?
	e 23a or	eral D		k Lake Dri  12. Was Decedent Ever in U.			4217	ecify Yes or No.	US.	American Indian,
9036	urs a	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☑ Divorced	Amed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		s, specify Cuba	dispanic Origin? (Span, Mexican, Puerto Specify:	Pican, etc.)		White, etc. Black
Maryland 21215-0036	e filed within 72 hours Il Hygiene. other than "natural", vent, the Madical Exp	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	1 1	's Usual Occup I of work done NOT use retired	during most of work  i)	ring 1	6b. Kind of Busir	nestio
yland 2	ould be fil Mental H arked oth	To Be C	17. Father's Name (First, Middle, Last) David Harp				18. Mother's Nam		ht	
	Health and 2 shorten 1 tem 27 le mother treum		19a. Informant's Name/Relationship (T) Alonzo Pendergri	ass/Son	660 F	Riorda	and Number or Rui	ce Ton	City or Town, Sta	D 21204
Baltimore,	Pages 1 ar nent of Hea ant: If Item ary or othe		20a. Method of Disposition  1 Burial 2 XiCremation 3 1  4 Donation 5 Other (Specify,	Removal from State	Place of Disposition semetery, cremato	ry or other plac	DB)	,	oc. Location - Cit Baltin	y or Town, State  70 Pe, MD
Balti	permit. Pages Department of Important: If I eny injury or once.		21. Signature of Funeral Service Licens			ame and Addre	ss of Excellity Val	John C.G	reene Fil MD 212	neral Services
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aa.	St	ne mode of dyin	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Examiner	_	Sequentially list conditions,	b. Due to (or as a conseq						
在760,		cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a conseq						
RLENE .O. Box 687	death certific e attending pl d for use as t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	I death 3 ☐ Ect	opic pregnancy her (specify)	,		23d. Date of Month	
ds, P.	igne bed	5	Part II. Other significant conditions co	ontributing to death but not res	ulting in the under	lying cause giv	ren in Part I.			ite to the cause of death?  Probably 4 QUaknown
Y C	The ge age	ompieted						24a. Was an autopsy perform	ed? prio	re autopsy findings available r to completion of cause of th? Yes 2 - No
Vita Ita	ysician:   is certifice director, p	Be C	25. Was case referred to medical examiner?	Hospital:		Oth	00	h  Check only one		
1X lion of	돈 돈 =	ation: To	1  Yes 2	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	4 1 I I I I I I I I I I I I I I I I I I	ome 5 Resider 28d. Describe how		Specify)
T. Divis	25 5 5	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street,	factory, office		28f. Location (Str. City or Town,		or Rural Route Number,
	Hospi 4 hour Funer ely fill	edicai (		iner: On the bast of my knu iner: On the basis of examina and manner stated.						
	within 2 To the complet	₩	29b. Signature and title of certifier	FAMIR CH	M D	29c. Licens	o 00 630		d. Date signed (I	Month, Day, Year)
	4		30. Name and address of person who o	completed cause of death (Item	n 23a) (Type, Print	t) Han	un Ch	une.	ND 11	17
	Stat Registra	_	31. Date filed (Month, Day, Year) DEC 1 3 2	32. Régistrar's Signa	iture Aps	of the	- 0) 06 1	112		'/

		1	1- State of Maryland / Per FH, G862, 12	722 Ce	rimeni <b>106dhi</b> tificate	of H	ealth a	and Me	ental Hy	giene Reg. No.	006	39669
	Physici	an	1. Decedent's Name (First, Middle, Last)  Emerson Jasper Hunt	Ĩ					2. Date of De Month	Day		3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number)		Ab City	Four or	Location of		vecemb	_	2, 2006 County of Deat	
	Examin	er	1 Lava Cowrt			ltin		n Death		40.	Baltin	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b. 225-54-1139 1√√ M 2□ F 60	irthday) Yrs.	If Under Months	1 Year Days	If Under :	24 Hrs. Min.	B. Date of Bir (Month, Da June 2	th Y. Year)	9. Bin 946 Ma	thplace (State or Foreign buntry) TYLand
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Toy	wn or Lo	cation							10d. Inside City Limits
	ne Maryis Be-f sho	ctor	Maryland Baltimore		Balti		2					1 □ Yes 2 ▼No
	with the	Dire	10e. Street and Number  1 Lava Cowrt		10f. Zip		1234			10g. Citi	zen of What Co	
	ns 23	eral	11 Marital Status 12. Was Decedent Ever in U.S.	13. \	Was Deced			gin? (Spec	ify Yes or No ican, etc.)	)-	14. Race - Ame	arican Indian,
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28e-f show tha Medical Examinar must be notified at	by Funeral Director	1 □ Never Married 2 □ Married 1 Never Married 2 □ Married 1 Never Married 2 □ No. 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 2 □ Married 1 Never Married 2 □ Never		lf Yes, spec 1 ☐ Yes 2		Specify:	i, Puerto R	ican, etc.)		Black, Whit Specify: frican	e, etc. White American
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121	within ene. than '	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT US Lder	e retirea,				Co	nstruct	tion
Maryland 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Departnent of Health and Mentat Hygiene. Importants if Item 27 is marked other than "natural", or items 23a or 28e-f show aimportants if Item 27 is marked other than "natural", or items 23a or 28e-f show aimportants of the real part of the real p	To Be Co	17. Father's Name (First, Middle, Last)  Edward Hunt					r's Name	(First, Middle,	, Maiden	Sumame)	
ary	2 shou and M is mar sumat	-			-						r Town, State,	
	and 2 ealth m 27 i		Emerson J. Hunt (son)						IV, B		more, N	ID 21236
ore	Pages 1 nent of He int: if Iter iry or oth		20a. Method of Disposition  1  Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other (Specify)									Maryland
Baltimore	permit. Pa Departmer Important any injury		' 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	22	2. Name and	d Addres	s of Facilit	Schi	munek	Fune	ral Hon	nes
<u></u>	89 E 29		かった	1							D 21236	
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a						respiratory a	rrest,		Approximate Interval Between Onset and Death
8760,	examined by sician and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence c. Due to (or as a consequence d.	IM e of):								10415.
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<u>α</u>	quires that n signed b uld be deta	ed by PI	Part II. Other significant conditions contributing to death but not resulting	in the u	nderlying ca	ause give	n in Part I.		23e. Did t		V	the cause of death?
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Vital	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?			Othe	E.		(Check only o			
of	ng Phy fter this neral d	lon: To	27. Manner of Death 1 Inpatient 2 EP/O 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b.	Time of Injury		Bc. Injury Work	4 🗆 Nu	28	e 5 🔀 Resid		S □Other (Spe y occurred	cify)
Division	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, full building, etc. (Specify)	farm, str					3f. Location (3 City or Tox			ural Route Number,
	e Hospita 24 hours e Funeral letely filled	edical C	29a. Certifier Certifying Physicien: To the best of my knowled (Check only one)  2 Medicel Exeminer: On the basis of examination a and manner stated.	ge, deat	h occurred a vestigation,	at the tim in my op	e, date an inion, dea	d place, ar th occurre	nd due to the d at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
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L	+1		30. Name and address of person who completed cause of death (Item 23a)  E-P. COSTLOW M.D. 10 G	(Type,	Print)	4uc	214	TIM			MD 2	
	Sta Regist		31. Date filed (Month, Day, Year)  32. Figgistrar's Signature		ويحدد							

		riease i	State of Mandar			_	_	
		For Stata	State of Marylar	•		_	2006	39676
		Ragistrar		Centifica	te of Death	2. Date of De	Reg. No.C. U U U	3. Time of Death
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4		5. Social Security Number 6. Sex			er 1 Year If Under 24	Hrs. 8. Date of Bir	<b>N/A</b>	thplace (State or Foreign
Funer: Directo			M 2×F 80	Yrs. Months		Min. 8. Date of Bir (Month, Da	y, Year) C.	thplace (State or Foreign ountry)  Maryland
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yland	1	10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits
a-f e	ç	Maryland N/A		Ba1	timore			1X Yes 2 □ No
th the	Director	10e. Street and Number		10f. Z	ip Code		10g. Citizen of What C	ountry?
27.2.1.5-UU36  9 within 72 hours after death with the Maryland jiene. rithen "natural", or Iteme 23a or 28a-f show the Medical Examinar must be notified at		1114 Newcomb Way			21205			S. A.
r dea	Funeral	Tr. Mariai Ciatos	<ol><li>Was Decedent Ever in U Armed Forces?</li></ol>	J.S. 13. Was Dec	edent of Hispanic Origin ecify Cuban, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Am Black, Whi	
S afte S afte	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 😾 No If Yes, Give	1 ☐ Yes	2 No Specify:		Specify:	White
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72 n	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Decedent's Us (Give kind of v life. DQ NQT	vork done durina most o	of working	Tob. Kind of Business	Viridustry
within ene then	E	Elementary/Secondary (0-12)  11th Grade	College (1-4or 5+)		lomemaker		Own 1	lome
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S a la b	To Be	William Phillips			E1:	sie Fox		
re, Maryland s 1 and 2 should be file f Health and Mental Hy Item 27 is marked oth other traumatic event	-	19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailing Addre			er, City or Town, State,	Zip Code)
and 2: and 2: ealth ar m 27 is		Karen Lee Braun (	Daughter)	3806 Haz	el Court.	Abingdon.	Maryland 21	1009
the Head		20a. Method of Disposition	20b. I	Place of Disposition (N cemetery, crematory or	ame of	Date	20c. Location - City or	
0 0		1 M Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		aith Cem. 12	2/12/2006	Baltimore,	Maryland
Baltimore, permit. Pages 1 at Department of Hea Important: If Item any Injury or othe	4	21. Signature of Fuperal Service Treense			and Address of Facility		Funeral Ho	
n ggg	8	1 44 Bl		3331	Brehms Land		re, Marylan	
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Dhysisis		shock, or heart failure. List only on Immediate Cause (Final	A A O L C s.t	Lati 20	ast Can	rov		Onset and Death
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BOX bath cer attendir for use	5	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	nancy al death 3 ⊟Ectopic	premiancy		23d. Date of de	
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IS, P.O. I res that the de signed by the a	by	Part II. Other significant conditions con	tributing to death but not re-	sulting in the underlying	cause given in Part I.		obacco use contribute t	~/
w require been si should I						_ 10	Yes 2 No 3 P	robably 4 Unknown
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of Vital Rec hysician: The law his certificete has t Il director, page 2 s	Completed						ormed? death?	s 2□No
itan: itan: artiflo ctor,	Be	25. Was case referred to medical examiner?			26. Place o	of Death (Check only		
hysic hysic ldire	2	1 ☐ Yes 2 No		☐ER/Outpatient 3☐ I		sing Home 5 Resi	dence 6 ☐Other (Spe	ecify)
DIVISION Of VITAL RECORDS, I or Attanding Physician: The law requires I effer death.  Director; Affer this certificate has been signs in by the tuneral director, page 2 should be a		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		how injury occurred	
SIO tendi eath. or: A	cati	2 Accident investigation 3 Suicide 6 Could not be		М	1 ☐ Yes 2 ☐ No			
or Att	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fact ify)	ory, office	28f. Location ( City or To	Street and Number or F wn, State)	lural Route Number,
DIVISION Of VITA  To the Hospital or Attending Physician: within 24 hours effer death.  To the Funeral Director; Affer this certifics completely filled in by the funeral director; I	ပိ							
Hose Hose Fund Bly fi	edicai	29a. Certifier 1 Certifying Phys	sician: To the best of my kn ner: On the basis of examin					
the the	Med	one) 29b. Signature and title of certifier	and manner stated.	1 2	9c. License number		29d. Date signed (Mon	th, Day, Year)
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		10000	~		M 100	CCU I	12/8/01	5
11	0	30. Name and address of person who co	impleted cause of death (Ite	om 23a) (Type, Print)	The MT	2122	100117	
	State		32. Remistrar's Sign	nature -		1021	+	
	State istrar	31. Date filed (Month, Pay, Year)	32. Redistrar's Sign	& Spark				

			State of Maryland / Dep		d Mental Hy	giene	
	at .	-	1. Decedent's Name (First, Middle, Last)	rtificate of Death	2. Date of De	Reg. No. 200	6 39671
	Physici	an		- l	Month	Day Yea	3. Time of Death
Y.	/Medic		James Howard Harn  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De		er 1, 2006	
)m	Examin	er	11509 Basswood Court		raui	,	
	Funeval		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Laurel ) If Under 1 Year   If Under 24 H	Irs. 8. Date of Bir	Prince G	irthplace (State or Foreign
Н	Funeral Director		460-46-0114   ¹¼M 2□F   73 Yrs.	Months Days Hours M	in. (Month, Da	y, Year) (	Country)
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	ylan <b>how</b> at		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	a-f s	cto	MD Prince George Laurel				1 ☐ Yes 2X No
	th th or 28 e noi	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What 0	Country?
	23a ust b		11509 Basswood Court	20708		U.S.A.	
	be filed within 72 hours after death with the Maryland that Hygiene.  did other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)	- 14. Race - An Black, Wh	
36	afte or if		1 ☐ Never Married 2 ☑ Married 1 ☒ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:	,	Specify:	,
21215-0036	hours ural'	d by	3 Widowed 4 Divorced Year or Dates: 1953-82	death Henri Ocean No		At	rican America
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Maryland	2 should be and Mental is marked ( aumatic ev	Ĕ		ing Address (Street and Number or		er. City or Town. State	Zin Code)
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ନ୍	一工多年		20a. Method of Disposition 20b. Place of Disp	osition (Name of	Date	20c. Location - City of	
0			1 Deurial 2 Defenation 3 Kinemoval from State	n Nat. Cem. 01/	02/2007	77-4	***
Baltimore,	permit. Page Department Important: If any injury or once.			2. Name_and Address of Facility	02/2007	Arlington,	virginia
B	Dep Dep Imp any onc		M00773	2. Name and Address of Facility Donaldson Funera 313 Talbott Ave.	l Home, P	.A.	0707-4390
	100		23a. Part1. Enter the disease or complications that caused the death. Do not en shock, or heart fallure List only one cause on each line.				Approximate
	Dhysisian		Immediate Cause (Final				Interval Between Onset and Death
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	Examiner		Due to (of as a consequence of).				
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Ĭ	The la	E O			-   autop	rmed?   death?	,
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<u> </u>	al or Attending P after death. I Director: Atter t d in by the funera	ific	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, so building, etc. (Specify)	reet, factory, office	28f. Location (S City or Tox	Street and Number or I	Rural Route Number,
5	s afte	Certification:	Balluling, stor (eposity)		City or 70	m, diate)	
	ospi hour uner		29a. Certifier (Check only (C	th occurred at the time, date and pla	ace, and due to the	cause(s) and manner	as stated.
	To the Hospital or Attending Physician: within 24 hours after deart.  To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical	one) wedical Examiner: Of the basis of examination and/of the		conteu at the time,	часе апи ріасе, апи п	ue to the cause(s)
	With To 1	2	29b. Signature and title of certifier	29c. License number	MD	29d. Date signed (Mor	
)			Jalle RAT SAMMWHAY RAT	Y WINDING !	MD icense	12-4-0	E
	inti	İ	30. Name and address of person who completed cause of death (Item 23a) (Type	Drint\		** * * * * * * * * * * * * * *	
	17		SATURGUATITY RIGHTANDON &	N DR. WEWDE	1. 140	CUNNSU.	
	Sta Registr		31. Date filed (Month Day, Year) 2006 33 Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day JESSIE EUGENIA HENDRIX December 8, 3:05 pM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harmony Hall Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ F Director 433-36-0939 81 18, 1925 LA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes ANNo Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6336 Cedar Lane 21044 U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∏Yes 2 🕅 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🛚 No 1 ☐ Yes 2 🛛 No Specify: Specify: White <u>م</u> 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grade 12 Florist Flower Shop is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John William Sutton ဂ Rachel Barr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Tonya Morley Granddaughter 9309 Kenbrooke Court Laurel, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Twin City Memorial 4 ☐ Donation 5 ☐ Other (Specify) 12/14/2006 West Monroe, LA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 23a. Part1. Enter the disease, of shock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia 2 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): anding physician a use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ☐ Yes 2 XNo 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XXIXnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ ★ ★ → 24a. Was an 1∐ Yes 2 🔀 🎌 2 **XX**0 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 ☐ Yes 2 ☑ 🛣 ပ 1 Inpatient 2 ER/Outpatient 3 DOA this Living 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1XXertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physiclan: within 24 hours a

To the Funeral [

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

Dr. Khan, M.D. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



and manner stated



29c. License number

D43323

Columbia, Maryland

29d. Date signed (Month, Day, Year)

21044

December 11, 2006

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed of

OFFON

ause of death (Item 23a) (Type, Print)

Registrar's Sign

29c. License number

MONTELHIR DR. ELLICOTT

29d. Date signed (Month, Day, Year)

			For State	State of Mary		artment of F rtificate of			000-	00071
	-		Registrar  1. Decedent's Name (First, Middle, Las	t)	Ce	runcate or	Dealli	2. Date of Deat	eg. No/ 116	3. Time of Death
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	and wo		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
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Maryland	200	To Be	FRANK KAPINO	S			ANI	NA PIS	Z	
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	s 1 and f Health item 27 other tr		THOMAS JELKS, JR 20a. Method of Disposition		105 Ob. Place of Dispo	S. DURHZ	AM STREE		IMORE, MD.	
Baltimore,			Marial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cred ST. STA	matory or other plac NISLAUS	CEM. 12	2/12/06	BALTIMOR	E, MARYLAND
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	To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completely filled in by the	Medical C	29a. Certifier 1 Certifying Phyone) 2 Madical Exam	ysician: To the best of m linar: On the basis of exa and manner stated.	amination and/or in	h occurred at the tirvestigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
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	4		20. Name and address of pers who cop	completed cause of death	(Item 23a) (Type,	Print)	SAVE	BAUT	mn 2121	5
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	th with the 23a or 28 ast be no	al Dire	9701 Viers Road			10f. Zip Code 20850			10g. Citizen of What C USA	ountry?		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: If Item 27 is marked other then "natural", or items 23a or 28a-f show say injury or other traumatic event, the Medical Examinar must be notified at ances.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? ( in, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.		
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	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature	site !			
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State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician ynthia. A. Lowery. 12:51 PM December 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner of Baltimore Baltimore Sinai Hospital If Under 1 Year | If Under 24 Hrs. Cynthia Lower 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 216-54-200 Usual Residence of Decedent 1 ☐ M 2 💢 Director laryland death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show important: If Item 37 is marked other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No **Funeral Director** timore 10g. Citizen of What Country? Street and Number nninghaus Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian. 11. Marital Status Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Patient known as 1 ☐ Yes 2 No Specify. altimore, Maryland 21215-0036 Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) should be filed within and Mental Hygiene. College (1-4or 5+) amount nterviewer 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) Ridge Censeties 12/11 21. Signature of Funeral Service Licensee W. lun Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cancer **Physician** ovarian Lim /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2. No 1 Tyes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 2- No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 📝 No 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation within 24 hours area Control to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) nber 5,2006 pleted cause of death (Item 23a) (Type, Print) Baltimore Zingman 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

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2006

ORIGINAL

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06-09355

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Erin Christine Lear	1	- For State	Sta	ate of Maryl		rtment of tificate of	Health and Death	Mental Hy		eg. No. 200	5 39570	
Physician	1	egistrar Decedent's Name (I							2. Date of Death Month Day Year December 8, 2006		3. Time of Death 0027 hrs	
Medical Examine		Eri 4a. Facility Name (if n		Leary	umber)		4b. City, Town, or L	ocation of Death	Decembe	4c County of Dea		
		Franklin Squa			,		Rossville		Baltimore County			
Funeral	7	5. Social Security Nun	nber	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Bir	th(MM/DD/YYYY) 9. I For	Birthplace (State or eign	
Director		213-77-0	832	1 M 2 X F		Yrs		Tiodio IVIIII	09/1	5/2006	Maryland	
any	L	Usual Residence of D	ecedent b. County		10c. City,	Town or Locat	ion		<u> </u>		10d Inside City Limits	
<u>*  </u>		MD	Balt	imore		Balt	imore				1 Yes 2 X No	
arylan	Ulrector	10e. Street and Numb					10f. Zip Code		1	0g. Citizen of What Co	ountry?	
with the Maryland ms 23a or 28a-f show be notified at once.	5	9529 F	ox F	arm Rd.			2	1236		USA		
more, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status  1 X Never Married	2 \_M	A al d	ecedent Ever in U. Forces?	.S. 13. Wa	is Decedent of Hisp es, specify Cuban,	panic Origin? (Sp Mexican, Puerto	ecify Yes or No Rican, etc.)	White, etc		
er deat	[	3 Widowed		orced If Yes, Give Yo		1	Yes 2 X No	specify:		Specify:	ite	
irs afte	ᆰ	15 Decedent's Educ		or Dates:		16a. Deceder	it's Usual Occupation	on (Give kind of w	vork done	16b. Kind of Busines	ss/Industry	
72 hot n "nal	Completed	Elementary/Second		_	(1-4 or 5+)	during m	ost of working life. I	DO NOT use retir	rea)	N/A	、	
0036 within tene er tha	틹		0		<u> </u>		N/A	8 Mother's Name	(First Middle	Maiden Surname)	1	
21215-0036  uld be filed within 72 hours after Mental Hygiene marked other than "natural", '	ည် ရှိ	17. Father's Name (Fi		Leary			l '			e R. Wate	erfield	
1D 2121( 2 should be fill 1 and Mental F 27 is marked matic event, 1	9 0	19a. Informant's Nam				100				mber, City or Town, St		
MD 12 sho th and th and an 27 is		Patrick		eary/ f	ather			Farm Ro	Bal	timore, A	MD 21236	
nore, MD 2 ages 1 and 2 shou nt of Health and N t: If item 27 is other traumatic		20a, Method of Dispo		n 3 Removal		Place of Disport crematory or of DILY H	sition (Name of cem her place)	Dec	cember 2006		River, MD	
altimore, rmit Pages I ar spartment of Hee iportant: If ite		4 Donation 5	Other S	pecify:	Mei	morial	Garden				100	
Baltimore permit Pages 1 Department of 1 Important: If injury or other		21. Signature of Fund	eral Service	Licensee		Ęv	Name and Address ans Fun Cremati	eral Ch	napel	8800 Ha Parkvil	arford Rd. le, MD21234	
Physician	$\dashv$	23a Part I. Enter the	disease, or	complications that	caused the death	n. Do not enter	the mode of dying,	such as cardiac o	r respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and	
/Medical		failure. List only Immediate Cause (Fi		Suddor	n infant de	eath synd	rome				Death	
Examiner		or condition resulting			a consequence of	of):						
4	ا <sub>ة</sub>	Sequentially list conditions if any, leading to imm		b Due to (or as	a consequence of	of):						
	Examine	cause. Enter Underl (Disease or injury that	ying Cause at initiated	C		of):						
vecuted n and - transit		events resulting in de	eath) Last	d.	s a consequence of	01).						
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tox 68760 eath certificate be attending physic for use as the bu	cian	past 12 months?		1	e birth gnant at time of d		etal death 3 L ther (Specify)	Ectopic pregna	aricy	Wioria	Day Fou.	
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cord aw rec has bee	Completed									ormed? death		
	Con						26 Place	of Death (Check	1 Yes	2 No 1 🗸	Yes 2 No	
Division of Vital Records, rater death rate the law requirers after death an Director: After this certificate has been sited in by the funeral director, page 2 should be in by the funeral director, page 2 should be a second or the funeral director, page 2 should be a second or the funeral director.	Be	25. Was case referre		Hospital:	Inpatient 2	✓ ER/Outpatier		Other	ng Home 5	Residence 6 0	ther:	
of V g Phyr fter thi	T0	1 ✓ Yes 2 27. Manner of Death		28a. Da	ate of Injury	28b. Time of		ry at Work?	28d. Describe	how injury occurred		
on cendin	tior	1 X Natural 2 Accident		nding				Yes 2 No				
ivisi or Att or Att Direct I in by	Certification:	3 Suicide	6 Co	uld not be 28e. P		home, farm, str	eet, factory, office b	building, etc.	28f. Location or Town,		r Rural Route Number, City	
spi hou fill		4 Homicide 29a. Certifier		ermined (Speci			and at the time of	ate and place and	d due to the car	use(s) and manner as	stated	
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi completely filled in by the funeral director,	Medical	(Check only one) 2	Certifying I Medical Ex	aminer: On the bas	sis of examination	and/or investig	ation, in my opinion	i, death occurred	at the time, dat	use(s) and manner as e and place, and due t	to the cause(s)	
To with To con	Mec	29b. Signature and t					29c Licens	se number		29d Date signed	(Month, Day, Year)	
		hi	1 6	i, mid			O.C.I	M.E.		December 8,	2006	
		30. Name and addre			ause of death (Ite	m 23a)		MD 04004				
		Ling Li, MD		ant Medical Ex	xaminer 11		eet, Baltimore,	MD 21201	-			
Sta Regist	ate rai	-	_	2006	Cognotial s Signa	K L	A.					
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Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

DEC 1

32. Registrar's Signature

			1 - For State Registrar	State of Marylar		artment of		nd Mer		ene 9. N2 () (	)6	39681
	Physici /Medio		1. Decedent's Name (First, Middle, Las Annie Miller	Murphy					Date of Death Month 12	Day 0 5 2	Year 2006	3. Time of Death 2:12 pm
_	Examin	er	4a. Facility Name (If not institution, give Grand Security Number 6. S	TAN HOSPIT			n, or Location of / MORE par   If Under 2	-	Date of Birth	4c. County	NA	(Chita on Francisco
, eg	Funeral Director				Yrs.	Months Da		Min.	Month, Bay, 09 03	Year) 1925	9. Birthpi Count	ace (State or Foreign  TY)  NC
	Maryland	ctor	10a. State 10b. County N/A	10c. C	Balti						10	od. Inside City Limits 1    Yes 2 No
	th with the 23a or 28	Funeral Director	10e. Street and Number 3609 Sequoia	- Avenue		10f. Zip Cod	21215		10	g. Citizen of V	Vhat Count	ry?
900	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ehow ita Modical Exaciliar Linas De notilian at	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 □ Yes 2 ☑No If Yes, Give Year or Dates:		Vas Decedent of Yes, specify C	of Hispanic Orig cuban, Mexican, No Specify:	in? (Specify Puerto Ric	y Yes or No- an, etc.)		e - America ck, White, e	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow way injury or other traumatic avent, the Marical Execution at the notified at angle.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 210 Grade	(ucation de completed)  College (1-tor 5+)	(Give	lent's Usual Ockind of work do	ne during most tired)	of working	1	6b. Kind of Bu	usiness/Ind	ustry
Maryland	ould be fill Mental Hy arked oth atic sveni	To Be	17. Father's Named (First, Middle, Last) JOSHUA DUPPE					's Name (F	irst, Middle, N	laiden Sumam	10)	
	and 2 shi ealth and m 27 is m			phy Husband	360	9 sea	***	Aven	ue Bo	ito. M	D 21	215
Baltimore,	Pages 1 ment of H tent: if ite		20a. Method of Disposition  1 Substitution 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, cren USOY		place)	2.13	06 (	Oc. Location -	MIL MIL	6 MD
Ball	Depart Depart Import eny in		21. Signature of Funeral Service Licen	Sio	1	1905 Y	ork Roa	d Bu	utimo	re MD		al sonices
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused the deal one cause on each line.	th. Do not ente	er the mode of	dying, such as c	cardiac or re	espiratory arre	st,		Approximate Interval Between Onset and Death
	/Medical Examiner	_	resulting in death)  Sequentially list conditions,	Due to (or as a consect b. INFECT	quence of): ED L/	NE						
Ž	xecuted end el-transit	Examiner	fl any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):							
68760,	tificate be executed ig physician end as the burial-transit	Ical		d.							-	_
P.O. Box	law requires that the death certificate be executed as been signed by the attending physician end 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	aldéath 3	Ectopic pregna Other (specify				23d. Dat Mor	e of deliver	y Day Year
	quires that in signed b	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the ur	nderlying cause	given in Part I.			acco use contr		cause of death?
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Vital	ysician: The is certificate hadinector, page	Be	25. Was case referred to medical examiner?			1		of Death C	1 Yes 2 Theck only one		☐ Yes 2	2 🗆 No
ō	Attending Physician: r death. sctor: After this certifici by the funeral director, i	atlon: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. le	Other: 4 Nur. njury at Work?	28d	5 Resider			)
Division	P Site	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre fy)	eet, factory, offi	Ce	281.	Location (Str. City or Town,	eet and Numb State)	er or Rural	Route Number,
	ne Hospital n 24 hours e ne Funeral I bletely filled	Medical (	29a. Certifier (Check only one)  Constituting Ph  2   Medical Examples	ysician: To the best of my kn hifter: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the restigation, in m	e time, date and ny opinion, deati	place, and n occurred a	due to the car at the time, da	use(s) and ma te and place, a	nner as sta and due to	ited. the cause(s)
)	To the I within 2 To the complet	Σ	29b. Signature and title of certifier.    Wy awd a	Som MD		RE	S 000			d. Date signed	5/2	006
	1		30. Name and address of person who of RIYAINKA SO	completed cause of death (Ite	m 23a) (Type.	Print) RAVE	V BLV.	D, B	ALTI	MORE	-212	239
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 3 2	32. Higistrar's Sign	dr. A	meli						

DHMH 17 Rev 1/2001

MURPHY, ANNIE

06-09281 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Tammi Regina Martin 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Month Day December 5, 2006 2246 hrs Medical Examiner 2 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give s Harbor Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Foreign Months Hours Director M Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c City, Town or Location 1 Yes 2 No 28a-f show hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country notified at "natural", or items 23a or 1100 Moneta Court Funeral . Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married Married Yes Divorced If Yes, Give Year 1 Yes 2 No specify: Widowed Specify event, the Medical Examiner ð or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Pages 1 and 2 should be filed within 72 lenet of Health and Mental Hygiene fant: If item 27 is marked other than "ror or other traumatic event, the Medical E. Elementary/Secondary (0-12) Baltimore, MD 21215-0036 irst Middle Maiden Surname Be ٥ 19b Mailing Address 2/20 Burial crematory or other place 2 Cremation 3 permit Pages
Department o
Important: I Other Specify 21. Signature of Funeral Service Licensee Part I. Enter the disease, or complications that caused the death. Do not enter the Approximate Interval **Physician** failure. List only one cause on each line. Cocaine and methadone intoxication Between Onset and /Medical Death a Cocaine intoxication Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical #10e, perFh, 23a, perME X UNPENDED X AMENDED physician the burial ician To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Ectopic pregnancy Year Live birth Fetal death 3 Day past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? P.O. ð 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24a Was an 24b. Were autopsy findings available After this certificate has been autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one 25. Was case referred to medical Be Other<sub>4</sub> DOA Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 🗸 Yes 2 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 1 Natural 1 Yes 2X No 5 Pending death ınknown within 24 hours after death To the Funeral Director: the Fnd 12/5/2006 unknown 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1100 Moneta Court Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be determined (Specify) residence Baltimore, 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d Date signed (Month, Day, Year) O.C.M.E December 6, 2006

96

31. Date filed (Month, Day, Year)

Theodore M. King, Jr., MD.

0 Name and address of person who completed & se of death (Item 23a)

32. Jegistrar's Signature.

Assistant Medical Examiner

ne of

111 Penn Street, Baltimore, MD 21201

State Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Calob Conrad Martin Certificate of Death Reg. No. . Date of Death Decedent's Name (First, Middle, Last) Physician/ Month 2123 hrs Calob Conrad Martin November 28, 2006 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Harford Harford Memorial Hospital Harve de Grace 8. Date of Birth (MM/DD/YYYY) 6 / 26 / 2006 9 Birthplace (State or 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24Hrs. 5. Social Security Number 219-75-0800 **Funeral** Hours Maryland Director 1 V M 2 F 0 Usual Residence of Decedent City, Town or Location 10d Inside City Limits 10b Count 10a State Harford Edgewood MD Yes 2 No 28a-f show with the Maryland Director e Street and Number 472 Sedgemore Ct. 10f. Zip Code 21040 10g, Citizen of What Country USA itenis 23a or Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S must be 1 Never Married Armed Forces? 2 Married Yes White 9 Divorced Yes, Give Year Yes 2 No specify Widowed ğ 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than " injury or other traumatic event, the Medical I N/A MD 21215-0036 N/A N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Billy Conrad Martin Terry M. Rust 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print ) Susan Rust- Grandmother 472 Sedgemore Ct. Edgewood, MD 21040 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Holly Hill Cemtery 12/15/06 Middle River, MD Donation 5 Other Specify mature of Fund Service Lice Evans Aftheral Chapel&Cremation Services Belair 3 Newport Dr. Forest Hill, MD21050 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Physician failure. List only one cause on each Between Onset and /Medica Death a Blunt Force Injuries to the Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause. Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and an/Medical UNPENDED AMENDED To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy phy the t 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day 1 Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Physici 1 Yes 2 No 9 Unknown Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. þ Yes 2 V No 3 Probably 4 Unknown ted 24a Was an 24b. Were autopsy findings available Complete autopsy prior to completion of cause of death? performed? 1 🗸 Yes ✓ Yes 2 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other<sub>4</sub> DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 1 🗸 Yes ပ 28c. Injury at Work? 28d Describe how injury occurred 28a Date of Injury (Month, Day, Year) FOUND: After 27. Manner of Death 28b Time of Injury fication: Subject struck on head FOUND 1 Natural Yes 2 🗸 No Pending within 24 hours after death To the Funeral Director: Nov 28, 2006 2000 hrs 2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 512 Bell Manor Road, Conowingo, MD Certi determined (Specify) Mobile Home 4 V Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E November 29, 2006 completed cause of death (Item 23a)

Registra DHMH 17 Rev 1/2001

OCME 2006

State

Pamela E. Southall, MD

31. Date filed (Month, Day, Year)

**ORIGINAL** 

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-09383 State of Maryland / Department of Health and Mental Hygiene Richard Merryman 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Time of Deat Physician/ Month Day December 9, 2006 Month 1005 hrs Medical Examiner Richard C. Merryman 4a Facility Name (if not institution, give street and number)
907 Bynum Time Road 4b. City, Town, or Location of Death 4c. County of Death Harford **Abinadon** Relair 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex **Funeral** Foreign Maryland Country Months Davs Hours Director 1 M 2 F 4/22/1938 68 219-26-4201 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any. 10a State 1 Yes 2 X No Belair 28a-f show Abingdon Harford MD with the Maryland Director 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number Hills 21015 USA 907 bynum Hill Rd. 9 23a 14, Race - American Indian, Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12 Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces Never Married 2 Married death 1 1 X Yes <sub>Specify</sub>hite Yes XX No specify: If Yes, Give Year Widowed Divorced "natural" ð 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Sears Elementary/Secondary (0-12) College (1-4 or 5+) uit. Pages I and 2 should be filed within 72 strment of Health and Mental Hygiene ortant: If item 27 is marked other than "ty or other traumatic event, the Medical I. Roebuck & Co. Baltimore, MD 21215-0036 than Repair Technician 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ellen Lorraine Kirkendall Be Richard Jones Merryman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 3449 James Run Rd. Aberdeen, MD 21001 Janelle C. Buttion 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a Method of Disposition Evans Funeral /13/06 Burial 2 X Cremation 3 permit. Pages
Department of
Important: 1 - Bel Air Forest Hill, Chapel Donation 5 Other Specify 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 3 Newpor Forest Hil 21. Sur Huy of Funeral Sept & Licens 21050 art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interva **Physician** Between Onset and ailure. List only one cause on /Medical a. Intraoral Gunshot Wound Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate he executed and Physician/Medical UNPENDED AMENDED attending physician or use as the burial -#4a-b,10c,10e,12,28f, perMD, FH, G862, 12/27/06 TI Box 68760, 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Fetal death 3 Ectopic pregnancy Month Day Live birth Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I by ģ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? . death? certificate has ✓ Yes 2 No 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> examiner? Nursing Home 5 Residence 6 Other. Scene DOA ER/Outpatient 3 Inpatient 2 this 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury After Manner of Death Subject shot self FOUND: Natural Yes 2 🗸 No 5 Pending 0947 hrs Dec 9, 2006 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) **Belair** 907 Bynum **Hill Roa**d, <del>Abingdon</del>, MD 3 V Suicide Could not be

Division of Vital Records, P.O. the Hospital or Attending Physician: n 24 hours after death

ne Funeral Director: A
sletely filled in by the fu To the

> Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Patricia Aronica-Pollak MD. 1 3 2006 Registrar's Signature

determined

Homicide 29a Certifier 1

Signature and title of certifier

(Specify) Residence

and manner stated

111 Penn Street, Baltimore, MD 21201

Death

Year

2 No

29d Date signed (Month, Day, Year)

December 10, 2006

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

O.C.M.E.

Medical

State Registra

29b

			For State Registrar	State of Ma	arylan		artmei <i>rtifica</i>				giene Reg. No		3	9685
		_	1. Decedent's Name (First, Middle, La	ast)						2. Date of Do			3.	Time of Death
i.	Physicia /Medic	_	William Emm	ett McFarl	Land	-				Decembe	er 8	3 200	6 9	:50 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, gi	ve street and number)			4b. City	, Town, or	Location of Deat	n	4c.	County of De	ath	
765			6513 Fallston Dr 5. Social Security Number 6.		e (In vrs I	ast birthday		krido r1 Year	Je If Under 24 Hrs.	8. Date of Bi	rth	Howard		(State or Foreign
И	Funeral Director		-	1 <b>⊠</b> M 2□F	70		Months		Hours Min.	Apr. 4	ay, Year) , 193	36 Pen	Country)	vania
	D		Usual Residence of Decedent		don Cit	. Taura and							T40.1.1	
	arylar show dat	-	10a. State 10b. County	3	· · · · ·	, Town or L								nside City Limits 1☑Yes 2☐No
	the M	Director	MD Howar	<u>a</u>	E	lkrid		p Code			10g Cit	izen of What 0		-
	aa or		6513 Fallston D	rive			101. 2	21075	5		rog. on	USA	, our my .	
	ms 2;	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.	S. 13.	Was Dec		spanic Origin? (S n, Mexican, Puer	pecify Yes or N	0-	14. Race - An		idian,
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 23a-f show aumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【 Divorced	Armed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates:	No		1 ☐ Yes		Specify:	to Rican, etc.)		Black, Wh		
Q Q	72 ho natur dical	eted	15. Decedent's I	Education rade completed)	V	16a. Dece	edent's Us	ual Occupa	ation during most of wo.	rkina	16b. K	ind of Busines	s/Industr	у
2	vithin ne. han "	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)				)	J				
א ס	filed v Hygie ther t int, th	ပ္ပိ	17. Father's Name (First, Middle, Las	Ø		Car	Sale	sman	18. Mother's Nai	ne (First, Middle		ıtomoti Surname)	ve	
au	eve eve	To Be	Leonard McFar							et POlla		,		
ary	should and Men s marke umatic	-	19a. Informant's Name/Relationship			19b. Mail	ing Addres	s (Street a	and Number or R			or Town, State	, Zip Coa	le)
	and 2 lealth a m 27 Is her trai		Shelly McFarland	/Daughter					n Parkwa		idge,	, MD 2	1075	
Baltimore,	of F		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	20b. P	Place of Disp emetery, cre	osition (Na ematory or	me of other plac	e)	Date	20c. Lo	ocation - City o	or Town,	State
<u>=</u>	permit. Pag Department Important: I any Injury c		4 □ Donation 5 □ Other (Spec		Wes	t Aru				9/06		enton,		
Ba	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice	170	40110				ss of Facility Do					P.A.
			23a. Part1. Enter the disease, or co shock, dr heart failure. List onl	1								1D 207	Apr	proximate
	Physician		shock, or heart failure. List onl Immediate Cause (Final disease or condition	y one cause on each lii COPD	ne.								Ons	erval Between set and Death
1	/Medical		resulting in death)	Due to (or as	a consequ	uence of):							-	
C	Examiner		Sequentially list conditions,	b										
_	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events	Due to (or as	a consequ	uence of):								
$\mathcal{D}^r$	execut and al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):								
68760,	ficate be executed g physician and ss the burial-transit	edical E		_d										
_		ledi												
Box	leath certifi attending I for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			□Ectopic	oregnancy				23d. Date of o		Year
о П	ne dea the at hed fo	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time of d	eath 5	Other (	specify)				WOTH	Day	Teal
P.0.	that the de ned by the a		Part II. Other significant conditions	contributing to death b	ut not resi	ulting in the	underlying	cause give	en in Part I.	23e. Did	tobacco	use contribute	to the ca	use of death?
Division or Vital Records,	es be	d by	Lung Cancer							15	Yes 2	□ No 3□	Probably	4 □Unknown
O O	law requir as been si 2 should	Completed	Congestive He	art Failure	3					24a. Wa		24b. Were	autopsy f	findings available
m m	The lay	mo								per	opsy formed? 2 <b>X</b> No	death	?	tion of cause of
/ita	yslcian: The iis certificate hadirector, page	Be C	25. Was case referred to medical examiner?							ath (Check only				
2	Attending Physician: r death. ector: After this certification of the funeral director,	은	1 ☐ Yes 2X No			ER/Outpatie			4 🗆 Nursing i	lome K Res			pecify)	
UC.	ding P. J. After t	ion:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Inju (Month, Da	y Year)	28b. Time Injury	M M	28c. Injun Work	yat k? Yes 2∐No	28d. Describe	now inju	ry occurred		
/isi	or Atten after death Director: in by the	Certification:	3 Suicide 6 Could not	be 28e. Place of inj								nd Number or	Rural Ro	ute Number,
$\leq$	i i i i i i i	erti	4 ☐ Homicide determine	building, et	c. (Specif	y)				City or Te	own, State	9)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (	29a. Certifier f ☐ Certifying I (Check only one)	Physician: To the best aminer: On the basis o and manner st	f examina	owledge, dea ation and/or i	ath occurre	d at the tir on, in my o	ne, date and place pinion, death occ	e, and due to the	e cause(s e, date an	and manner d place, and d	as stated lue to the	I. cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1			2	9c. License	e number		29d. Da	ite signed (Mo	nth, Day,	Year)
			ZXalut	Bower	, MI	0		D554	137		Dec	ember	8, 2	006
	IXI		30. Name and address of person wh	,	leath (Iten	n 23a) (Type								
			Elizabeth Bowe				ngham	Way,	Woodst	ock, MD	211	.63		
	Sta Registi		31. Date filed (Month Day, Year)	006 Registr		The same of the sa	An - Elegan							

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 12 AM 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner NA tucility Da/Amore Nursing 7. Age (In yrs. last birthday)

GG Yrs. If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF Hours 215-22-9375 7 Virginia Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show other traumatic event, the Medical Examinar roust be notified at Bultimore 1 €¥es 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 5009 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Black ρ Specify: 3 Widowed 4 Divorced "natural" Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hyglene. ant: If Item 27 Is marked other than ' ury or other traumatic event, the Mu Elementary/Secondary (0-12) Colfege (1-4or 5+) omestic TouseKee Der 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) tedge Washing 19a. Informant's Name/Relationship (Type, Part) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4601 W. Northern trunces 200: Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23. Name, and Address 1701 MC lars funeral Service Wa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EMENT Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No autopsy performed 1 Yes 21 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signaruje and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 240 LOUR 31. Date filed (Month, Day, Year)
DEC 1 3 2006 32. Registrar's Signature State 1 3 2006 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 7,2006 DECEMBER /Medical 4b, City, Town, or Location of Death Facility Name (If not institution, give street and number 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 212-56-784 Director Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Director NIA MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 1810 E 21213 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Alouse Drug ounselor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( (PICKEND) MUREHARD 2 19b. Mailing Address (Street and Number or Rural Route Number, City or To-n, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara 2/28 4040 Hullers Rd. Baeto md 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zi on 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Dec 16,2046 Landsdown, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rincied a Brayen Funeral Service 270 Fried Hillow Pars, Balti, ma Baeth, md 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** STROKE Sequentially list conditions, if any, leading to Infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) attending physician for use as the burial Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dil 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital

or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

St. BAHIMORG, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Begistrar's Signature

31. Date filed (Month, Day, Year) 3 2006

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

BALTIMORE

Davs

10:20 AM

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

18 HOURS

7 HOURS

HOURS

Year

1 ☐ Yes 2 No

Maryland

2006

Specify: White

23d. Date of delivery

O Donnell St.

DECEMBER 9,2006

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No

Month

4c. County of Death

BALTIMORE

PECEMBER

8. Date of Birth (Month, Day, Dec. 23,

Dèc.

Year

1952

**Physician** /Medical Examiner

**Funeral** 

ELLEN

JOHNS HOPKINS

Social Security Number

216-62-1608

4a. Facility Name (If not institution, give street and number)

6. Sex

1 M 2 F

BAYVIEW MEDICAL CENTER

7. Age (In yrs. last birthday)

53

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036 **Physician** 

**Examiner** and Division or Vital Records, P.O. Box 68760, attending physician

/Medical Hospital or Attending Physlclan: The law requires that the death certificate be executed filled in by the funeral 24 hours after death. Funeral Director: A To the Hosp within 24 hot To the Fune completely fi

Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County MO Director Baltimore Nottingham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4421 Camellia Rd USA 21234 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore County College (1-4or 5+) 5+ Elementary/Secondary (0-12) Public Schools Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lotta Fotia Joseph Fotia, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4421 Camellia Road, Nottingham, MD 21236 Jack A. Nehmsmann (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 12/14/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Euneral Service Lionises 9705 Belair Road, Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final CEREBRAL disease or condition resulting in death) Due to (or as e consequence of) A 18 CHOUSEN ROLLY SELLED SUBARA CHNOID HEMOPRHAGE Saturatially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine TRAUMATIC HEAD WANDER IN THE PARTIES OF THE PARTIES Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≨</u> 1 Tes 2x No 3 Probably 4 Unknown Be Completed 24a Wasan autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1**X** Yes 2□ No 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural 1 Tyes 2X No 281. Location (Street and Number or Rufal Route Number, City or Town, State) 1640 PM 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide 5500 Block 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortified

MD

32 Registrar's Signature

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

2006

MICHAEL AWAD,

31. Date filed (Month, Day, Year)

DEC 1 3

DHMH 17 Rev 1/2001

State

Registrar

4940 EASTERN AVENUE, BALTIMORE, MARYLAND

RES-000

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Mary Agnes Pennewell DEC. 2006 12:30p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1107 Taylors Island Road Madison Dorcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Days Hours Min. 81 Yrs. Director 219-16-8229 APR 15, 1925 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Medical Examiner must be notified at 1 Tes 2 No Directo Maryland Dorcester Madison 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö 21648 1107 Taylors Island Road USA items 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Å Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 □ Divorced White "neturel", 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental is marked William Joseph Baublitz Bertha Carter Baublitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amos Pennewell, III/son item 27 6425 Woodbine Road Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Depertment of P
Important: if ite
eny injury or ot
once. 1 □ Burial 2 □ Cremation 3 □ Removal from State Crestlawn Memorial Gardens 12/14/06 4 ☐Donation 5 ☐ Other (Specify) Marriottsville, MD 22. Name and Address of Facility
Haight Funeral Home & Chapel
P.O. Box 195 Sykesville, MD 21784 (410-795-1400) 21. Signature of Funeral Service Licensee Dan Moderal of 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death stroke Immediate Cause (Final day Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospitel or Attending Physicien: The law requires that the death certificate be executed W use as the burial-transit Exami that initiated events ettending physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 209No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 Yes : After this certification and the section of the s 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Ratural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only To the P 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Lugene

31. Date filed (Month, Day, Year)

Vavmir

3

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dec 7, **Physician** Charles Henry Proctor 2006 1:03 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Washington DC **Funeral** Months Days Hours Min 1 X M 216 30 4360 71 Director Usual Residence of Decedent death with the Maryland 10h. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐Yes 2 ☐ No Director Maryland Prince George Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13924 Tower Road 20613 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give XX Year or Dates: 1 Never Married 2 Married Specify African American 1 ☐ Yes 2√√No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Work Elementary/Secondary (0-12) College (1-4or 5+) 10 <u> Supervisor (Tree Trimmer)</u> Department of Public permit, Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Renzie Proctor Mary Mable Proctor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Edna Proctor (Wife) 13924 Tower Road, Brandywine, MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Ser Alexandria Ferry Road, Clinton, MD 23a. Firt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician yocardia /Medical as a consequence of) Examiner Sequentially list conditions, if any trading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) burial-trai Due to (or as a consequence of) physician the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitai Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Mountvamer, M.D. 7503 Surratts Road, Clinton, MD\_20735 32. Regionar's Signature 31. Date filed (Month, Day, Year) DEC 2006 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		For State Registrar	State of Maryland		artment of H <i>rtificate of L</i>		-	giene Reg. No.	06	39691
==0.5		Decedent's Name (First, Middle, Last)					2. Date of De	eath		3. Time of Death
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/Med Exami		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of De		4c. County		
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Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days		lin. (Month, Da	ay, Year)	9. Birthplac	ce (State or Foreign
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and w		Usual Residence of Decedent  10a, State 10b, County	10c. City	, Town or Lo	cation				10d.	. Inside City Limits
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ns 23	Funeral		2. Was Decedent Ever in U.	S. 13.			(Specify Yes or No uerto Rican, etc.)		e - American	Indian,
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		23a. Part Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death						I A	pproximate nterval Between
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p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):					- 1	
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icate be executed physician and sthe burial-transit	<u>e</u>		Due to (or as a consequ	derice of).						
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the o	ιγsi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□Unknown							
s that	by Pi		tributing to death but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use cont	tribute to the	cause of death?
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To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	wledge deat	th occurred at the ti	me date and n	place and due to the	e cause(s) and m	anner ac stat	ted
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orthin comply	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	ed (Month, Da	ay, Year)
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State of Maryland / Department of Health and Mental Hygien 2006

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2006 8-12-4 all 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner wither Newsing Lenter 9 If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex 🕖 5. Social Security Number **Funeral** Months Days 1 □ M 250 F Director 3PC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "neturel", or items 23a or 28e-f show traumatic event, the Medical Exercited at 1 ☐ Yes 2 No **Funeral Director** Charlesel J 10g. Citizen of What Country? 10f, Zip Code 10e, Street and Number 31234 CAON 1810 - 08825 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 250 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other traumatic event. College (1-4or 5+) Elementary/Secondary (0-12) 137/151 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HUOUSEM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AD THE JAMIL K. 1810 Largez 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition DEC. 13, Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ONIZOZI ODOW 900F 21. Signal to of Fun ray Service Licensee 22. Name and Address of Facility AND LASTONA 1001 ROGO IERGILAND 31337 3800 HARFOR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only gine cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) circhosus Pnysician /Medical Due to (or as a consequence of): Examiner encephanopathy heperice Sequentially list conditions, any, cause to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner be executed burial-transit Mner Due to (or as a consequence of): ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown ATK Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after c To the Funeral Direct completely filled in by 4 Thomicide To the Hospitel 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00064104 Dec-11.06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towson MD 21204 10 Sauce 4202 6701 SIMIN SUSTANI N.Charles 31. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For Stata Registrar	State of	Maryland		artment of		nd Mental Hy	giene Reg. Na2 0 0	6 39693
	Physici /Medic		1. Decedent's Name (First, Middle Diane	R.		Robii	nson		2. Date of D. Month	Day	3. Time of Death
	Examir		4a. Facility Name (If not institution Prince George			er	4b. City, Town,	or Location of Cheve:		4c. County o	f Death e George's
	/ Funeral Director		5. Social Security Number 209-40-6152	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. la 56	ast birthday) Yrs.	If Under 1 Yea Months Day		Min. 8. Date of Bi	<sup>th</sup> 4,1950	9. Birthplace (State or Foreign PA
	aryland ehow	<u>.</u>	Usual Residence of Decedent  10a. State 10b. County	0 1	10c. City	, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	vith the Mi	Directo	Maryland Prince  10e. Street and Number				linton 10f. Zip Code	20735		10g. Citizen of Wh	
36	172 hours after death with the Maryland "naturel", or itema 23e or 28e-1 ehow idical Examinar must be notified at	by Funeral Directo	3600 Strawberr  11. Marital Status  1 Never Married 2 Marr  3 Widowed 4 Tolvorced	12. Was Dece Armed For	dent Ever in U.S ces? 27 No		Was Decedent of f Yes, specify Cu	Hispanic Orig ban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)		- American Indian, White, etc. African American
21215-0036	E . C	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	c's Education of grade completed)  College (1	-4or 5+)	(Give life.	dent's Usual Occ kind of work don DO NOT use retii Program	e during most red)		16b. Kind of Bus	
Maryland 2	be filed ital Hygi id other event, I	To Be Co	17. Father's Name (First, Middle, James Jami	Last)	1		TTOGTAN	18. Mother	's Name <i>(First, Middle</i> ncy Betto	, Maiden Sumame,	
	nd 2 shouth and 27 is m		19a. Informant's Name/Relations Rena Robinson		)				or Rural Route Numb 1 Drive C1		ryland 20735
Baltimore,	90 = 5		20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State _ ce	ace of Dispo metery, crer Crema	sition (Name of matory or other po atory		Dec. Data 2006		ity or Town, State , Maryland
Balti	permit. Pag Department Important: I any njury o		21. Signature of Funeral Service	Licensee	0015				Lee Funer dria Ferry		Inc. nton, MD 20735
	Physician /Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on ea	aused the death ach line.	etu	0		eardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
	Examiner and prijetusii	Ical Examiner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (	or as a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence	ence of):	Me to	sta	10 mg	_	Montes
P.O. Box 687	death certificate e attending phy od for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live bi	come of pregnar inth 2   Fetal ant at time of de wn	death 3	Ectopic pregnan			23d. Date Mont	,
	quires that n signed b	þ	Part II. Other significant condition	1	ath but not resu	fting in the u	nderlying cause g	oven in Part I.		· V	oute to the cause of death?
il Records,	: The law requires that the cete has been signed by th page 2 should be detache	Completed	HY	ier co ag	, vest	s S	the		24a. Was auto perfi 1 □ Yes	psy pri ormed? de	ere autopsy findings available or to completion of cause of ath?
	Attending Physician: It death. ector: After this certifice by the funeral director, i	tlon; To Be	25. Was case referred to medical examiner?  1  Yes 2  No  27. Manner of D ath  1  Natural 5  Pendin 2  Accident investig	g 28a. Pate o	npatient 2 E	ER/Outpatien 28b. Time of Injury	28c. In	ther: 4 🗆 Nur			
Division	il or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could in determined	not be 28e. Place	of Injury - At hor ng, etc. (Specify,	me, farm, str	eet, factory, office	9		Street and Number wn, State)	or Rural Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the Examiner: On the ba and mann	sis of examinati	vledge, death ion and/or in	n occurred at the vestigation, in my	time, date and opinion, death	place, and due to the coccurred at the time.	cause(s) and mann date and place, an	ner as stated. id due to the cause(s)
)	To the To the Complete	Me	29b. Signature and title of certifier	halfe	) egr			0052	865	29d. Date signed (	Month, Day, Year) Ler 9 2006
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13	Sta Registr	1500	31. Date filed (Month, Day, Year)  DEC 1	3 2006	gistrar's Signat	J. A	carte				

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			For State	State of Maryla	•	rtificate of		III WIC			39694
			Registrar  1. Decedent's Name (First, Middle, Las	st)		timouto or		2.	Date of Death	. 140,	3. Time of Death
п	Physicia		Frederick William	n Byan				1	Month December		125 AM
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of			4c. County of	Death
			Howard County G	eneral Hospit	al	Colum	bia			Howar	:d
	Funeral Director		217 02 2071	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Days		Min. S	Date of Birth (Month, Day, Y ept 6,	1959	). Birthplace (State or Foreign Country) Jamaica
	and W	}	Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	cation					10d. Inside City Limits
	daryli f eho	ō	MD Anne Ar	undel	Laurel						1 □ Yes 2 □ No
	28a-	Director	10e. Street and Number	under	Баагст	10f. Zip Code			100	. Citizen of Wh	
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	deat	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	Hispanic Orig	gin? (Specif	y Yes or No-		American Indian, White, etc.
92	or It		1 Never Married 2 Married	1 □Yes 2 XXIIo If Yes, Give		1 □ Yes 2XXXVo		,	,	Specify:	White
ğ	within 72 hours affer death with the Maryland ene. Than "naturel", or items 23s or 28s-f ehow Its Meulcal Evandrar must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual Dccur	nation		16	b. Kind of Busi	
수	in 72	Completed	(Specify only highest gra	ade completed)	(Give	kind of work done DO NOT use retire	during most	of working	10	b. Kilid of buşi	nessinoustry
212	d with piene.	mo	Grade 11	College (1-4or 5+)	Dr	iver				Duron E	Paint Co.
Maryland 21215-0036	al Hyg	Be C	17. Father's Name (First, Middle, Last)	)			18. Mothe	r's Name (F	First, Middle, Ma	iden Surname)	
<u>a</u>	Menta	2	Assad I. Fatta				Lyne	ette E	Beharie		
lan,	2 sho and ls my	Į į	19a. Informant's Name/Relationship (			ng Address (Street					, ,
<u>ຂ</u>	and lealth om 27 lher t		Lynette M. Ryan  20a. Method of Disposition	/ Mother		Eagle Ha	rbor S	outh,			and 20724 ity or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inpartment of Health and Mental Hygiene.  Inpartment of Health and Mental Hygiene.  In a Medical Evanination to see the notified at the profile of all once.		1 ☐ Burial 2XX remation 3 ☐	Removal from State	cemetery, crei	matory or other pla					
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Division of Vital Records,	Physicien: The law requires thet the death certifical this certificate has been signed by the ettending phyrai director, page 2 should be detached for use as the	ed by									☐ Probably 4 ☐Unknown
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	To the Hospital or Attanding Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical		hysician: To the best of my k miner: On the basis of exam- and manner stated.							
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•			P / leke los a	-14 m / re 1450	2 mis		8500		D	and	10 2006
	10		30. Name and address of person who	completed cause of death (I	tem 23a) (Type,	Print)	, 4 7	) _ /	1 /	111.	7 1/22.2
	Sta	ato	31. Date filed (Month, Day, Year)	32/Registrar's Sir	nature	1910186	Li I	111	Oluke Di	13 11111	4/1940 21044
	Regist		DEC 1 3 2	completed cause of death (III	Di Aff						

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 09,2006 Year **Physician** 6:05P M Dec. Marilyn C. Romar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Air ear If Under 24 Hrs. 1323 Southwell Lane Harford Bel 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 1 M 2 F Yrs. 09.04.1929 NY Director 089.30.3018 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Funeral Director Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21014 USA 1323 Southwell Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21X No Baltimore, Maryland 21215-0036 White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Leasing Manager Apartment Complex 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Meade Lillian Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert J. Romar/husband 1323 Southwell Lane Bel AirMD 21014 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 3 ☐Removal from State Chesapeake Crematory 12/12/06 Beltsville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility CAFA 21. Signatine of Funeral Service Licensee 🕽8717 Green Pastures Dr. Baltimore MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or a consequence of): **Physician** CANCER Six months /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1☐ Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient ٩ 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 🕅 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier f 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0

State

Registrar

MARK 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

NORTH 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

BELAIR MARYLAND

december 11, 2006

21014.

		-	- State Amend item#2	State of perMD,	Marylan	d / Depa perMF Ce	artmen 1862 Tificati	19137 e of L	ealth a Death	and M	ental Hy	giene	006	39696
			Decedent's Name (First, Middle								2. Date of De	ath		3. Time of Death
1	Physicia	_	Katie F. Sumle	r							Month 11	06	2006 Year	3:00 P M
	/Medic Examin		4a. Facility Name (If not institution		nber)		4b. City,	Town, or	Location of	of Death			County of Deat	
	1	•	3310 Barcroft	Drive			Spi	ingo	lale			F	rince G	eorge's
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🗓 F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birt Co	nplace (State or Foreign untry)
R	Director		337-20-2647	1 ⊔ M 2 LAT	8	3 Yrs.					11-22-			hez, MS
	pu s	-	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	ed all	5		1			_							1 ☐ Yes XXNo
	28a-1	Director	MD Princ	e George'	s   5pi	ingdal	10f. Zip	Code				10g. Cit	izen of What Co	untry?
	with Ba or	0	3310 Barcroft D	rive			2077					T	ISA	
	ne 25	Funerai	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	cify Yes or No		14. Race - Ame	
ယ	or ite	Ē	1 ☐ Never Married 2 ☐ Marri	Armed Fo ed 1 ☐ Yes	2 🔀 No		ir Yes, spec 1 ☐ Yes		n, mexicar Specify:	i, Puerto	Rican, etc.)		Black, White	_
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or iteme 23a or 28a-f ehow the Medical Examinar mual be notified at	l by	3	If Yes, Giv Year or D	ates:		10 165	2 <b>/</b> 0 140	Specify.				Specify: Bla	CK.
5-0	72 h	Completed	15. Decedent (Specify only highes			16a. Dece (Give	kind of wo.	rk done a	<i>durina</i> mos	t of worki	n <i>g</i>	16b. K	ind of Business/	ndustry
2	nen. hen.	mpi	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT us		")			D	+4-+ O1-	
2	tygie her t		12th 17. Father's Name (First, Middle,	l act)		МЭ	niste	er	18. Mothe	er's Name	(First, Middle	_	tist Ch	uren
anc	t be filed ntal Hygid od other: event,	Be	Moses Holiday	Fletcher							y Haywe		Beard	
Maryland	should nd Mer marke umatic	2	19a, Informant's Name/Relations			19b. Maili	ng Address	(Street a					r Town, State, Z	Tip Code)
¥a	nd 2 s lith ar 27 ie r treu		Sandra Goins/Da	ughter		3310	Barci	oft	Driv	e, Sı	oringda	1e,	MD 2077	4
ē,	f Heal		20a. Method of Disposition			Place of Disposemetery, crei	sition (Nar	ne of			ate		ocation - City or	
9	Page ent o nt: If ry or		1 ∰Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State	. Норе				1-18-	-2006	Chi	cago, I	L
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "neturel", or Items 23a or 28a-1 show eny injury or other treumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Septice	icensee	, ,	22	2. Name an	d Addres	s of Facili	yMars	shall's	Fun	eral Ho	me
ä	Depa Impo eny is		Aulia	Mara	hall								, Wash.	DC 20011
			23a. Part1. Enter the disease, or spock, or heart failure. List	complications that conly one cause on e	aused the deat ach line.	h. Do not en	er the mod	e of dyin	g, such as	cardiac c	or respiratory a	irrest,		Approximate Interval Between
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687	ficate phys			d										
Box (	nding use a	N/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			70						23d. Date of del	very
	death certifica e attending ph ed for use as th	icia	in the past 12 months? 1 ☐ Yes 2 🕅 No	4□Pregn	inth 2 ☐ Feta ant at time of c		∃Ectopic pi ∃Other (sp						Month	Day Year
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on	tending leath. tor: After the funer	tion	1 X Natural 5 ☐ Pendin 2 ☐ Accident investig	g (Mon	th, Day Year)	Injury	М	28c. Injun Worl 1 ☐ `	k? Yes 2 □				,	
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ă	al or after al Direction of in the	Certification:	4 Homicide	buildi	ng, etc. (Speci	ny)					City or To	wri, State	"	
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	9		mich	J. Cla	2480	UNL	V	D5	7042				1110,	1806
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State of Maryland / Department of Health and Mental Hygiene

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		I- For State Certificate of D	eath	Reg.	No. 2001	3969
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			City, Town, or Location of Death		4c. County of Death Baltimore Cou	
· / _ · · · ·			f Under 1 Year If Under 24Hrs	8 Date of Birth/	MM/DD/YYYY) 9. Birt	
Funeral Director			Months Days Hours Min.	`	Foreig	n
Bilector		218-56-1633   1 x M 2 F   54 Yrs.		May 28,	1952	untry) MD
n y		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	·			10d Inside City Limits
10 wa	١. ا	MD DAT HITMODE				1 X Yes 2 No
daryland 28a-f show any 1 at once.	횽	MD BALTIMORE  10e, Street and Number 11	Of. Zip Code	10g	Citizen of What Cour	itry?
ne Ma or 28 fied a	Director	532 N. DECKER ST.	21205		LICA	
72 hours after death with the Maryland n"matural", or items 23a or 28a-f sh al Esaminer must be notified at once	eral [		ecedent of Hispanic Origin? (Spi	ecify Yes or No-	USA 14 Race - Ameri	can Indian, Black,
eath v item ust b	Fune		specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
fter d			s 2 X No specify:		Specify: BLA	CK
ours a atura	d by		Jsual Occupation (Give kind of w		6b. Kind of Business/I	ndustry
72 h 72 h rai fra	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	of working life. DO NOT use retir	ea)		
3036 within 72 iene er than '	E G		DRIVER		TRUCKING	
15-C iled v Hygi d oth		17. Father's Name (First, Middle, Last)	18.Mother's Name		,	
21215-00; ould be filed with a Mental Hygiene s marked other t ic event, the Me	o Be	HOWARD LEE SMITH  19a Informant's Name/Relationship (Type, Print )  19b. Mailing Ac	ANNIE IN  Idress (Street and Number or R	IAE DOUGI		Zin Codo)
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene m 27 is marked other than aumatic event, the Medica	Ĕ		,			
Tore, MD 2 ages 1 and 2 shou nt of Health and N nt: If item 27 is n other traumatic	1	HOWARD D. SMITH, SR. 1023 S	MARLYN AVE.	Date 2	20c. Location - City or	Town, State
		1 Burial 2 X Cremation 3 Removal from State crematory or other				ONNELL ST.
ti. Partmen		4 Donation 5 Other Specify: BAYVIEW CR 21 Signature of Fundral Service Licensee 22. Nam	e and Address of Facility WES	3/2006	BALTIMORI	E, MD 21224
Baltimo permit. Page: Department o Important: injury or oth			07-09 EASTERN A			
Physician		23a. Part I Enter the disease or complications that caused the death. Do not enter the r				Approximate Interval
/Nedical		failure. List only one duse on each line.  Immediate Cause (Final disease a Narcotic intoxication				Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):				
	١. ا	Sequentially list conditions, b.				
	ineı	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				· · · · · · · · · · · · · · · · · · ·
ecuted and transi		d		-		
ian ian	/Medica	X unpended #23a,27,28a-f, perM	E, g862, 12/16/06	IT		
68760, certificate be nding physic se as the bur	/Me	IF FEMALE. 23c If yes, outcome of pregnancy			23d. Date of delivery	
certif	cian	past 12 months?	death 3 Ectopic pregnal (Specify)	ncy	Month D	Pay Year
Box e death c	Physician	1 Yes 2 No 9 Unknown 9 Unknown	(Opeony)		i .	
P.O. Box 687 s that the death certific gned by the attending p e detached for use as th	P.	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
, P.O ires that t	d by			1 Yes	2 No 3 Prob	ably 4 Unknown
ords, w requires been as been as been as should	Completed			24a. Was an autopsy		topsy findings available ompletion of cause of
Reco The law icate has	Ĕ			perform 1 ✓ Yes 2	ed? death?	
tal Rection: The certificate	ပို	25 Was case referred to medical	26.Place of Death (Check of			
Vita hysicia this ce	Ď	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	DOA Other Nursing	g Home 5 Re	esidence 6 Other	
1 of Vital Records, ling Physician: The law require After this certificate has been si funeral director, page 2 should b	ایا	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	y 28c. Injury at Work?	28d Describe how	w injury occurred	
ion tendii eath or: /	ļį.	Natural 5 Pending Pending Investigation Fnd 12/1/2006 Fnd 7:35 p	m 1 Yes 2 X No	unknown		
Division pital or Attendit ours after death eral Director: A	ij	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, f	actory, office building, etc	28f. Location (Stre	eet and Number or Ru te) 1023 S. Ma	ral Route Number, City
Division Hospital or Attent 24 hours after death Finneral Director: tely filled in by the	Certification:	4 Homicide determined (Specify) found at residence		Essex, MD	1025 5. 12	11yii Avenue
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death cupietely filled in by the funeral director, aget this certificate has been signed by the attending competeely filled in by the funeral director, page 2 should be detached for use as		29a Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred one) 2 Medical Examiner: On the basis of examination and/or investigation				
To the Ho within 24	Medical	and manner stated				
	2	29b. Signature and title of certifier	29c, License number  O.C.M.E.		29d Date signed (Mor	
		highi, mo	U.U.IVI.L.		December 2, 200	
AT		30 Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street,	Baltimore, MD 21201			
U	tate	31. Date filed (Month, Day, Year)  32. Registrar's Signature				
Regis		DEC 1 3 2006 Seem &	N .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#/, perFH C862, 12/13/06, WS State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** JAMES SATTERFIELD 12 7:00 PM 2006 П /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE UNION MEMORIAL HOSPITAL N/A 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday).
72 73 Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F 72 JAN.9,1934 NORTHCAROLINA Director 40 6716 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director MD. BALTIMORE CITY N/A10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21218 2309 HOMEWOOD AVE. usa Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. 1 Yes 3 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No BLACK Specify. Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10TH <u>MAINTENANCE</u> MONDAWMIN MALL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MAJOR SATTERFIELD ODELL ROGERS မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BALTO, MD. 21218 RICHARD SATTERFIELD(brother) 2309 HOMEWOOD AVENUE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Burial 2 □ Cremation 3 ☐Removal from State DEC.16,2006 BALTO,MD. TRINITY CEM. 4 Denation 5 ☐ Other (Specify) 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME ture of Funeral Service Licensee PRESTON ST. BALTO, MD. 141 E. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ANCER **Physician** METASTATIC KNG yeur disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, isaming to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s certificate 1☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Sala AT2438946 MD 201 E. University PARKELLAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memorial Hospital BOLAO Ballimore n. Union MD 21218 31. Date filed (Month, Registrar's Signature State Registrar

			For State	State of Maryla				, 0	2006	20600
			Registrar  1. Decedent's Name (First, Middle, Las.	t)	Cei	rtificate of	Deam	Reg 2. Date of Death	. N6_ U U U	3. Time of Death
	Physicia	4	Julian	Edward	Soude	rs		Month /	Day Year	1:50p M
	/Medic Examin		4a. Facility Name (If not institution, give				r Location of Death	12	4c. County of Dea	
	LAGIIII		Prince George's	Hospital		Ch	everly		Prince G	eorge's
	Funeral Director		5. Social Security Number 6. Security Number 577-32-4518	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth May 23,17	reary Co	thplace (State or Foreign puntry) hington, DC
			Usuel Residence of Decedent						wasi	illingcon, bo
	anylan show	L.	Manual and Brain as Co		Conit	cation ol Height	C			10d. Inside City Limits
	Ba-f	5	Maryland Prince Ge	orge s	Сарти		.5			1 ☐ Yes 2 ☐ No
	h with ti	ai Dire	10e. Street and Number 917 Highview	Drive		10f. Zip Code 2C	743	109	J. Citizen of What Co U.S.	ountry? A.
9	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ariment of Health and Mental hygiene. ortent: if Item 27 ie marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, I'm Medical Examination into the incilling all injury or other traumatic event, I'm Medical Examination into the incilling all all.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 15☐Yes 2☐No If Yes, Give	1951-	Was Decedent of Hif Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
8	hours urai',	d b	3∑Widowed 4 □ Divorced	Year or Dates: 19	03			140		
5	n 72 i	lete	15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work	sing 16	b. Kind of Business	/Industry
212	withi	E	Elementary/Secondary (0-12)	College (1-4or 5+)		akery Sup			Bakery	
and ;	id be filed ental Hygi ked other ic event, I	To Be C	17. Father's Name (First, Middle, Last) William I. Sou	uders				ne <i>(First, Middle, M</i> a an E. Bai		
Baltimore, Maryland 21215-0036	and 2 should be I salth and Mental I n 27 le marked o	<b> -</b>	19a. Informant's Name/Relationship (7.  Julian M. Soude		19b. Mailir 435	ng Address <i>(Street)</i> 75 Drum C	and Number or Rui Cliff Road	ral Route Number, C	City or Town, State, 2 od, Mary 1	<i>Zip Code)</i> and 20636
nore,	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.		20a. Method of Disposition  ★★Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, crer	sition (Name of matory or other place ion Cemet			c. Location - City or	Town, State, Maryland
altir	mit. P partme portan / injur		21. Signature of Funeral Service License		22	. Name and Addre	ss of Facility Le	e Funeral	Home, In	c.
Ö	permi Depa impo any ii	l il	Mark les	Tah 1901	53 6	633 Old A	lexandri	a Ferry R	oad Clint	on, MD 20735
			23a. Part1. Enter the disease, or composhock, or heart failure. List only of	plications that caused the decore cause on each line.	ath. Do not ent	er the mode of dyin	ig, such as cardiac	or respiratory arrest		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a - 5EV	(-R	CANDIE	my 0124	my		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):		A			
		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):	C 1)8	31CH41	HMH		
3,	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	- 1	INA1	Tws	wiffi C	iency		
ó	exec an an rial-tr	Еха	resulting in death) Last	Due to (or as a conse	equence of):			HariA iency FAIC		
8760,	icate be executed physician and s the burial-transit	dicai		d a	DN605	わひら	UCALL	FAIC	uno	
9	entifica ing ph	Med	IF FEMALE:		<del></del>				1	
.O. Box	The law requires thet the death certific ste has been signed by the attending p page 2 should be detached for use as i	by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of preging the pregnant at time of 9 Unknown	tel death 3 [	Ectopic pregnancy Other (specify)			23d. Date of del Month	livery Day Year
٥.	that the de led by the a detached f	Ph	Part II. Other significant conditions co	ontributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ords	w requires their been signed to should be det							1 ☐ Yes	2 □ No 3 □ Pr	robably 4x Unknown
Records,	The law re te has be age 2 sho	Completed						24a. Was an autopsy performe	d?   death?	utopsy findings available completion of cause of
ital	ian: ortifice ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)	140	2010
Ž <	Physician: r this certific ral director,	은	1 ☐ Yes 2 K∑XNo		☐ ER/Outpatier		4   Nursing no	ome 5 Residenc	e 6 □Other (Spe	cify)
Division of Vital	ling P	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe how	injury occurred	
isi	or Attending after death. I Director: After d in by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be		home farm str		Yes 2 □ No	28f Location (Stree	et and Number or Ru	ural Route Number
<u>&gt;</u>	s after ni Dire ed in b	Certification:	4 Homicide determined	building, etc. (Spec	cify)	oot, tastory, onloo		City or Town, S		Toble Wallborn
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificete his completely filled in by the funeral director, page	edical	29a. Certifying Phy (Check only one)	ysician: To the best of my kr niner; On the basis of examir and manner stated.	nowledge, death nation and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
	within To the comp	Σ	29b. Signature and title of certifier			29c. Licens		_	. Date signed (Mont	h, Day, Year)
,	1041		30. Name and address of person who c	completed cause of death (Ite	om 23a) (Type,		05370	11-	10-(1)	00-
			ISION BERHAN	'E 3001 HR	SPITAL	DR CHE	VEKIY,	MO 20	1/85	
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Sign	H. Los	de				
				100	0 /					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #10c&g State of Maryland / Department of Health and Mental Hygiene I / Oh Jh

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year Ralph Edward Smith 2006 /Medical 6:05A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Hospice Care
5. Social Security Number 6. Sex / 7. Age (In yrs. last birth Towson
If Under 1 Year | If Under 24 Hrs. Baltimore irthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 514.26.0845 03.20.1921 KS Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits sa or 28a-f sh t be notified a 1 ☐Yes No Director SC Georgetown Murrells Inlet 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ns 23a ( 49 Longcreek Drive U.S.A. 29576 U.A.A. Funeral ral", or Items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Ses 2 No If Yes, Give Year or Dates: 10142-1 Never Married 2 Married "natural", or i Baltimore, Maryland 21215-0036 1 ☐ Yes 2DKo þ Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Medical Veterinarian 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Ralph Gustav Smith Nell Campbell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If Item 27 any Injury or other trong once, Karen Smith/Wife Murrells Inlet SC 2
Date 20c. Location - City or Town, State 49 Longcreek Dr. 29576 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 4 □ Donation 5 □ Other (Specify) 12.13.06 Beltsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Cremation And FuneralBalto Alternatives Pastures Dr. MD

Approximate Interval Between Onset and Death 8717 Green 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** nough /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospo 1 Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 124 hours after death.

Ne Funeral Director: A pletely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho

To the Function

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) ecenber 12, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11) A Riley CATA 6701 N. Charles St. Boolito and 31. Date filed (Month, Day, Year) Begistrar's Signature State **DEC 13** 2006 Lieberson Registrar

		1	1- State of Maryland / Department of Certificate of		ntal Hygiene	71116 39 <i>1</i>	01
	Physicia /Medic	an	Decedent's Name (First, Middle, Last)     Lisa Lynn Taylor		Date of Death Month Day 2-10-200		
	Examin		800 W. 37th Street Balti	n, or Location of Death	4c.	County of Death	
64	Funeral Director		5. Social Security Number 218-84-3295 6. Sex 1 Months 1 Months Day 43 Yrs.	vs Hours Min. (	Date of Birth (Month, Day, Year) -16-196	9. Birthplace (State of Country)  3. Maryland	r Foreign
	Maryland f show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location Baltimore			10d. Inside Cit 1 ☑ Yes	
	with the ? 3a or 28a-	I Director	10e. Street and Number 800 W. 37th Street 2121		10g. Cit	izen of What Country?	
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland carment of Health and Mental Hyglene. ortent: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar mout to notified at injury or other traumatic event, the Medical Examinar mout to notified at e.g.	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes, Sive 1 Vidowed 4 Divorced 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No	of Hispanic Origin? (Specify Cuban, Mexican, Puerto Rica No Specify:		14. Race - American Indian, Black, White, etc.  Specify: White	
21215-0036	vithin 72 hou ne. han "natura a Madical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ne during most of working tired)		ind of Business/Industry	
3	d be filed within ental Hygiene. ked other than conert, the Mer	To Be Co	12 N/A Secretary  17. Father's Name (First, Middle, Last)  George Gary Taylor	18. Mother's Name (Fin	rst, Middle, Maiden		
Maryland	d 2 shou th and M 7 is mar traumati	-		eet and Number or Rural Ro		or Town, State, Zip Code)	
ē,	Pages 1 and nent of Health int: if item 27 iry or other to		20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other) Evans Funeral	place) 12 Pate	20c. Lo	ocation - City or Town, State rest HIll, M	D
Baltir	permit. Pages Department of importent: if i eny injury or once.		21. Signal re Il Suneral Service Licensee 22. Name and Ad Peacefu	ddress of Facility	ivesFune	eral&Cremati onium,MD 210	on
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. Laryngeal aresulting in death)	dying, such as cardiac or re-	spiratory arrest,	Approximat Interval Bet Onset and 0	e ween
	/Medical Examiner		Due to (or as a consequence of):				
6	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
8760,	⊕ × ⊕	Cal	d.				
.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of delivery  Month Day	Year
Δ.	quires that t n signed by uld be deta	۵	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.	23e. Did tobacco	use contribute to the cause of c	death? Unknown
Il Records,	The law requir cate has been si page 2 should	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 📆 No	24b. Were autopsy findings prior to completion of odeath? 1 □ Yes 2 □ No	available ause of
f Vital	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1   Yes   2   No	26. Place of Death (Continued) Other: 4 ☐ Nursing Home		6 ☐Other (Specify)	
ion of	ing After une		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury 28c. 1 Accident investigation		. Describe how inju		
Division	tal or Attend s after death al Director: / ed in by the f	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, off building, etc. (Specity)	ice 281.	Location (Street at City or Town, State	nd Number or Rural Route Nurr e)	iber,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the basis of examination and/or investigation, in many and manner stated.	ne time, date and place, and ny opinion, death occurred a	due to the cause(s at the time, date an	s) and manner as stated. d place, and due to the cause(s	3)
	To t To t	Σ		p 6179 p	29d. Da	ate signed (Month, Day, Year)	
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 55  Harry Yoon 1550 Orlean St, 5m	3, CRB2, Baltim	are mo 2	1231	
1	St Regist	ate rar	Harry Youn 1550 Orleans St., 5 m  31. Date filed (Month, Day, Year) DEC 1 3 2006  32. Registrar's Signature	•			

			For State Registrar	State of I	Marylan	•	artmen tificate			and Me	•	giene Reg. Ng2 ()	06	3970	12
	Physici /Medic		1. Decedent's Name (First, Midd MICHAEL BR	UCE TILL	ETT						2. Date of Dea Month Decemb		200 <sup>Y</sup> ear	3. Time of De	
	Examin		4a. Facility Name (If not institution 3108 Northwind		er)		4b. City,	Town, or Bal	Location of timor	of Death C			nty of Death Baltim	ore	
	Funeral Director		5. Social Security Number 217-64-1857	6. Sex 7. 1 M 2 □ F	Age (In yrs. 52	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da January	<sup>h</sup> 1, 195	9. Birth	place (State or F ntryland	oreign
	ahow		Usual Residence of Decedent  10a. State 10b. Count  MD 1	Baltimore	10c. Ci	ty, Town or Lo	cation Balt	imor	e					10d. Inside City I	
	with the N a or 28a-f Lee could	Direct	10e. Street and Number 3108 Northwi				10f. Zip	Code	234			10g. Citizen		ntry?	
980	n 72 hours after death with the Maryland "netural", or Items 23e or 28es-f ahow polcal Exercises mant the cotilled at	by Fur	11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	12. Was Decede Armed Force ried 1 Tyes 2	es? K∐No		Was Deced f Yes, spec		ispanic Ori in, Mexicar Specify:		cify Yes or No Rican, etc.)		Race - Ameri Black, White, ecity: Wh		
21215-0036	ywithin piene. r than "	Completed		nt's Education est grade completed)  College (1-4	or 5+)	(Give	dent's Usua kind of wor DO NOT us ice A	rk done d e retired	du <i>ring</i> mos 1)	t of workin	g		f Business/ir ell Ch	evrolet	
Maryland ?	be file ital Hy of othe	To Be C	17. Father's Name (First, Middle John Thomas		r						(First, Middle, ed Free		name)		
	s 1 and 2 should Health and Men Item 27 Is marke other traumatic		19a. Informant's Name/Relation Margaret Tille			3108	North	wind	Road	d-Bal	Route Number	,Maryla	and 21	234	
Baltimore,	800 = -		20a. Method of Disposition  1	Specify)	ale   , /	Place of Disponentery, crein	on Cei	meto	ny	2/13	3/06	Balt	on - City or T	(ml)	
Ball	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service 23a. Part1. Enter the disease, of	Mª Jas	loh	A	VANS ND CR	FUNI EMAT	CION S	CHAPE SERVI	ш <b>с</b>		ord Ro lle,Ma	ad 2 ryland	1234
68760,	death certificate be executed  Wedical  e attending physicien and for use as the burial-transit	Ical Examiner	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. As phy Due to (or  b. Due to (or	as a consect as a consect as a consect	by L quence of):	iang	ına	3					Interval Betwe	
O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outco 1 □ Live birll 4 □ Pregnar 9 □ Unknow	h 2∏Feta ntattime of d	aldeath 3	Ectopic pr Other (sp						Date of deliv Month	reny Day Yea	ar
s, P.	quires that the de n signed by the a uld be detached	þ	Part II. Other significant condit	ions contributing to dea	th but not res	sulting in the u	nderlying c	ause giv	en in Part I			obacco use c		the cause of dea	
Il Record	ian: The law requires that the rificate has been signed by th tor, page 2 should be detache	Completed									24a. Was autor perfo		tb. Were auto prior to co death? 1 🗆 Yes	opsy findings ava empletion of cause 2000 No	ailable se of
Division of Vital	r Attending Physician: ter death. Irector: After this certific n by the funeral director.	Certification: To Be	3 Suicide 6 □ Could	Hospital: 1 □ Inp. 28a. Date of (Month, Inp. 1 not be mined 28e. Place or building	Injury Day Year)	28b. Time o Injury 6844 nome, farm, st	AM 2	8c. Injur Wor 1 🗆	er: 4□Ni	ursing Hom 2	Suic	dence 6 how injury och de by Street and Numer, State)	Hang Limber or Rur		ş9 ·
	To the Hospital o within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier 1 Certify (Check only one)	ing Physician: To the b I Examiner: On the bas and manne	is of examin	owledge, deat ation and/or in	ivestigation	, in my o	pinion, dea	nd place, a ath occurre	and due to the ed at the time,	date and place	ce, and due t	to the cause(s)	
	Tot You	M	29b. Signature and title of earli	am the	Da	Ltn	1	) (	S.C				nbes	Day, Year)	0
	10		30. Name and address of person Philip Militel  31. Date filed Month, Day, Yea	LO,MD 6	Trim	PleH	211:	T. L	utha	11:un	e,MD	210	93		
ER.	Sta Regist		31. Date filed Month, Day, Yea DEC 1 3	2006	gistrar's Sign	ature	le								

06-09			Please Type or Print in Black Indelible Ink. Ensure All Copie		ble.
Debo	orah Vanker	•	n State of Maryland / Department of Health and Mental Hy 1- For State Certificate of Death		m 2006 3970:
	Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death	3. Time of Death
Med	lical Exami		Deborah Van Kempen  4a Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	Month D December 4	, 2006 1457 hrs
			4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  820 Cator Avenue  Baltimore		N/A
	Funeral Director	- 1	5. Social Security Number 6. Sex 17. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.  1 Months Days Hours Min.	- 1	MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
	nd show any ice.	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD N/A Baltimore		10d. Inside City Limits 1 Yes 2 No
	ith the Maryland 23a or 28a-f show notified at once.	Director	820 Cator Avenue 10f. Zip Code 21218	10g	Citizen of What Country? USA
	r death w	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		14. Race - American Indian, Black, White, etc.  Specify: Whit-
	ours afte atural", amine	d by	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of voluming most of working life. DO NOT use retired.		6b. Kind of Business/Industry
	21215-0036 Id be filed within 72 hours after Mental Hygiene narked other than "natural", event, the Medical Examiner	Completed	12tharade A years Animal Technicia	n	Medical
	215-0 be filed w ntal Hygic rked othe ent, the M	Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name  Morgo	(First, Middle, Mai	nd
	D 2121; should be fill and Mental H 7 is marked	ם	19a. Informant's Name/Relationship (Typ. Print)  19b. Mailing Address (Street and Number 1  19b. Mailing Address (Street and Number 1  19b. Mailing Address (Street and Number 1  19b. Mailing Address (Street and Number 1	at D Ca	er, City or Town, State, Zip Code)
	ages I and 2 shount of Health and Mit. If item 27 is not their traumatic		20a Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2	20c. Nocytion - City or Toylon, State
	Baltimore, bermit. Pages I a Department of He Important: If ite		4 Donation 5 Other Specify: Urlenmount Cremotory 14	08/06	Baltimore MD
	Balti permit. Departm Importa injury o		an W. Suo 5151 Baltimore Na	Honal Pik	e Balto. MD 21229
	Physician /Medical	700	23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line		t, shock, or heart Approximate Interval Between Onset and Death
	Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Pentobarbital thenytonin and ethanol intoxical disease or condition resulting in death)	acton	
		ner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause		
./	ed	Exami	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.		
V	e execute cian and rial - tran	dical	X UNPENDED #23a,27,28a-f, perME, g862, 12/16/06	TT Amend#	1 perME
	68760, certificate be nding physici	cian/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live hirth 3 Ectopic pregnancy	- 10	23 Date of delivery  Month Day Year
	Box 6: e death cert the attendii		past 12 months?  4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 V Unknown  9 Unknown		
	O at the	by Phy			acco use contribute to the cause of death?  2 ✓ No 3 Probably 4 Unknown
	ds, P. equires the signe auld be de			24a. Was an	24b. Were autopsy findings available
	Vital Records, hysician: The law requir this certificate has been sold director, page 2 should 1	Completed		autopsy perform 1 ✔ Yes 2	ned? death?
	tal Rection: The certificate ector, page	မ္မ	25. Was case referred to medical 25. Place of Death (Check	only one)	
	of Vita ing Physici After this o	10 B	1 V Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 North		esidence 6 🗸 Other: Scene
	on of \ nding Ph; th r: After tl e funeral		27. Manner of Death    1		injected drugs
6	Division pital or Attendi ours after death neral Director: /	Certification	2 Accident Investigation 11th 12/4/2000 11th 2.50 pm Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Str or Town, Sta	reet and Number or Rural Route Number, City ate) 820 Cator Avenue
	Divis Hospital or A 24 hours after Funeral Dire			Baltimore	<u>, MD</u>
	To the Host within 24 hd To the Fun- completely i	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated	at the time, date a	nd place, and due to the cause(s)
	To To	Me			29d. Date signed (Month, Day, Year)
			hy hi, his o.c.m.e.		December 5, 2006
	8		30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		

State Registrar DHMH 17 Rev 1/2001 OCME 2006

31. Date filed (Month, Day, Year)
DEC 1 3 2006

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Linda Hilda Vykol December 2006 1143 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2□F Director 212-48-2490 May 23, 1947 Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ortant: if item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Md. Harford Director Abingdon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 500 Kirkcaldy Way 21009 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: þ white 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be in nent of Health and Mental Health and Mental William C. Corkran Lillian M. Mach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Petra Payne/daugher 500 Kirkcaldy Way, Abingdon, Md. 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Gardens of Faith Cem. 12/11/06 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximately a such as cardiac or respiratory arrest, shock or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** lears /Medical Due to (or as a onsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ician and burial-trans Due to (or as a consequence of) physician the burial VKOL LINDO IV 180038 2. Division or Vital Records, P.O. Box 6876 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month ģ Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 I Inknown 9 Unknown signed by to d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has b irector, page 2 s autopsy 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient P After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of 4 ☐ Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certine completed cause of death (Item 23a) (Type, Print) ddress of person wh esapeake Dr. Bel Air 31. Date filed (Month, Day, Year) State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Margaret Valmai Wylie DEC. 9 2006 3:58a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist Hospice 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🕁 F 220-60-1041 Director 65 1940 16. Australia Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Howard <u>Glenwood</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or? 3574 Sharp Road 21738 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Professor Interior Design 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mona O'Connor William Pascoe ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 273 Clarksville, MD 21029 Ronald J. Wylie/spouse permit. Pages 1 and Department of Healt Important: if item 2 any injury or other? 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State Grestlawn Memorial Gardens 12/18/06 Marriottsville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21. Signature of Funeral Service License Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one use on each line. 21784 (410-795-1400) Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading a immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-transit signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of D ath 1 DNatural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □ Yes 2 □ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral Hospital the

(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Gerald Wilson-Maxfield Certificate of Death 1- For State Registrar Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day December 2, 2006 2057 hrs **Medical Examiner** Gerald Arthur Wilson 4b. City, Town, or Location of Death 4c County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Bowie Health Center 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY) 7. Age (In yrs last birthday) 5. Social Security Number 6. Sex **Funeral** Country) DC Months Days Hours 09/23/1984 Director 22 216-27-7174 1 X M 2 Usual Residence of Deceden 10d Inside City Limits IOc. City, Town or Location 10b. County any 1 X Yes 2 No 28a-f shov Bowie or items 23a or 28a-f showmust be notified at once. Prince Georges Maryland death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20715 USA 12507 Scarlet Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14, Race - American Indian, 8lack Funeral 12 Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Armed Forces 1 X Never Married 2 Married 2X No Yes Yes 2 X No specify: White 3 Widowed 4 Divorced f Yes. Give Year "natural", ğ 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 beament of Health and Mental Hygiene trant: If item 27 is marked other than "n or other traumatic event, the Medical E Baltimore, MD 21215-0036 Chief of Maintenance Pet Care 10 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Melissa Ann Maxfield Be Craig Steven Wilson 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 12507 Scarlet Lane Bowie, MD 20715 Melissa Wilson/ Mother 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 X Cremation 3 Removal from State 12/10/2006 Waldorf, MD partment c Huntt Crematory Other Specify Donation 5 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Narcotic intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or Injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X AMENDED X UNPENDED sician a #1,23a,27,28a-f, 2862.12/21/06 TT Box 68760 23d Date of delivery ing phy: as the b IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>о</u> Yes 2 No 3 Probably 4 Unknown ş Completed of Vital Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? ✓ Yes 2 icate page 26.Place of Death (Check only one) 25 Was case referred to medical To the Hospital or Attending Physician: After this certif Be Other<sub>4</sub> Hospital: 1 examiner? DOA Nursing Home 5 Residence 6 Inpatient 2 🗸 ER/Outpatient 3 1 V Yes 2 28d Describe how miury occurred 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 27. Manner of Death Certification Natural Yes 2 X No Pending unknown the f Fnd 12/2/2006 | Fnd 8:10 pm Director: Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12507 Scarlett Lane 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide determined within 24 hours at To the Funeral L (Specify) found: residence Bowie MD Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier O.C.M.E 12/3/2006 Orgente 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Margarita Korell MD. 31 Date filed (Morths Pay, Year) State 2006

Registrar

			1 - For State Registrar	State of Maryland		artment of		d Mental Hygie		5 39707
	Physici: /Medic		1. Decedent's Name (First, Middle, Last,	WHI	TINO	Ś		2. Date of Death Month	Day Yea	
	Examin Funeral	er	4a. Facility Name (If not institution, give  3404 Sudlersville  5. Social Security Number  6. Se	S.		4b. City, Town,  Laure  If Under 1 Yea  Months Day	f If Under 24 h		Anne Arr	
	Director Mod		414-34-7248   Usual Residence of Decedent   10a. State   10b. County	79	Yrs.			May 21, 1		rginia  10d. Inside City Limits
	ith the Mar or 28e-f et	Director	MD Anne Aru	ndel La	urel	10f. Zip Code	1-	10g.	Citizen of What	1 Tyes 2 No
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heetih and Mentalle Hygiene. Important: If tiern 27 is marked other than "natural", or items 23a or 28e-f show eny injury or other treumatic event, the Madical Examinar must be notified at once.	by Funeral	3404 Sudlersville  11. Marital Status  1 Never Married 2 Married  3000 Married 4 Divorced	S.  12. Was Decedent Ever in U.S Armed Forces?  1		207 Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 🛣 N	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No- verto Rican, etc.)	Black, Wi	merican Indian, hite, etc. White
1215-0	vithin 72 ho ne. han "natur e Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give life.	DO NOT use retii	e during most of red)	working	o. Kind of Busines	ss/industry
Maryland 21215-0036	ld be filed w ental Hygier ked other ti Ic event, In	To Be Cor	12th 17. Father's Name (First, Middle, Last) Benton Medley	Ø	Ger:	iatric N		Aide Name (First, Middle, Mai Ce Parsons	Self Emp den Sumame)	oloyed
, Mary	end 2 shou eelth and M n 27 le mar	-	19a. Informant's Name/Relationship (Ty Roberta Baxley/Dat	Rural Route Number, C. Jessup, MD	r, City or Town, State, Zip Code)  MD 20794					
Baltimore,	permit. Pages 1 Department of He Important: If iter eny injury or oth		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens	Ft.	Linco 22		12/ ress of Facility	/11/2006 E		d, MD
) 1	Physician /Medical Examiner	ē	23a. Part1. Enjer the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate	Due to (or as a consequence).	Do not ent		ring, such as card	nue, Laurel, diac or respiratory arrest,		Approximate Interval Between Onset and Death
8760, 中	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent.	ence of):	TN				years
.O. Box 6	thet the death certific ed by the attending pl detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of deal 9 ☐ Unknown	death 3	Ectopic pregnan Other (specify)	су		23d. Date of d Month	lelivery Day Year
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		Completed						24a. Was an autopsy performed	24b. Were prior to death?	
Ĭ	Physicien: rthis certifior ral director.	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital:	-		thon	Death Check only one		
ion of	Attending Physic death.  ector: After this by the funeral di	atlon: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		R/Outpatien 28b. Time of Injury	28c. In	4 🗀 14013111	28d. Describe how i	e 6 ⊡Other (Sp njury occurred	pecify)
DIVIS	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)				City or Town, S	tate)	Rural Route Number,
	To the Hospital or within 24 hours efter to the Funeral Dir completely filled in	Medical	one)	ner: On the best of my knowner: On the basis of examination and manner stated.	on and/or in	restigation, in my	opinion, death of	ccurred at the time, date	and place, and di	ue to the cause(s)
	F 3 F 0		Hospice of	ief Medical Of the Chesapeak	е	D	21438	290.	1207/0	
	Sta Registr		30. Name and address of person who commichael J. LaPo 31. Date filed (Month, Day, Year)		5 Defe		hway, An	napolis, MD	21401	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death r 2, 2006 Month **Physician** Joseph Charles Arbin, Sr. December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6705 Boston Avenue Baltimore n/a If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Year) Aug 31, 1919 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1√2 M 2 □ F 87 218-14-9239 Maryland Director Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 in marked other than "naturel", or iteme 23s or 28s-1 show other traumatic event, the Medical Exeminar must be notified at 1 XYes 2 No Director Md. n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 6705 Boston Avenue Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 (∑Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 and 2 should be filed within 72 hours after withelth end Mental Hygiene. •m 27 ie marked other then "naturel", or itel 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 Specify δ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Huckster Produce 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Arbin Marie Grau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6705 Boston Avenue Baltimore, Maryland21222 Joseph Arbin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery 12-15-06 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility aczorowski Funeral Home, PA 21. Signature of Funeral Service Licens 1201 Dundalk Ave. Baltimore, Md. 21222 Twing 400 23a. Part 1. Enter the diseas , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prostate Physician Uncer /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner anding physicien and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown pege 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 1 ☐ Yes To the Hospital or Attending Physician: nerel Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours 29a. Certifier 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DOD64434 December 13, 20010 mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Bultimore MD 21224 Windy Bennett Ave 12. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 1 4 2006 Registrar DHMH 17 Rev 1/2001

		•	For State Registrar	State o	Maryland		artmen rtificat			nd M	ental Hy	giene , Reg. No. 4	2006	3970	
44	Physici /Medio		1. Decedent's Name (First, Middle, PEA	*		ABELL					2. Date of De Month DECEM	Day	Year 2006	3. Time of Death 4:30 P	
	Examir	er	4a. Facility Name (If not institution, g	GHTS AVE	NÚE #30					TIM			ounty of Death	N/A	
	Funeral Director		5. Social Security Number 219-14-1345  Usual Residence of Decedent	.Sex 1□M 2√F	7. Age (In yrs. Ia		If Under Months	1 Year Days	If Under 24 Hours	Mrs. Min.	8. Date of Bir (Month, Da 12/21	71924	9. Birth	place (State or Foreign ntry) MD	
	with the Maryland a or 28a-f show be notified at	tor	10a. State 10b. County	/A	10c. City	, Town or Lo	cation	RE						10d. Inside City Limits	
	leath with the	ral Director	10e. Street and Number 6711 PARK HEI	GHTS AVE	NUE #303	3	10f. Zip	Code	2121	15		10g. Citize	n of What Cou	usa	
980	72 hours after death with the Maryland natural", or items 23a or 28a-f show dikal Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marriec 3 ሺ Widowed 4 □ Divorced	Armed Fo	dent Ever in U.S rces? 2 No e ates:		Was Deced If Yes, spec 1 ☐ Yes 2		spanic Origir n, Mexican, l Specify:	n? (Spe Puerto I	cify Yes or No Rican, etc.)		. Race - Americ Black, White, pecify:		
Maryland 21215-0036	within iene. than "	Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)	Education grade completed) College (1	-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during n life. DO NOT use retired)  SALES			ation luring most o	on 1 ring most of working			16b. Kind of Business/Industry HANDBAGS		
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	es 1 and 2 should by Health and Ment item 27 is marked rother traumatic e		19a. Informant's Name/Relationship WENDY GRODNIT		JGHTER	5 CH	ELLIS	COU		NIW	GS MIL	LS, M	Town, State, Zip D 21117		
Baltimore,			20a. Method of Disposition 1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		State C6	ace of Dispo emetery, cren NA CEM	natory or o	ther place			ate 3/2006		DALE, N		
Ball	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lie	lute	He		8900	REI		TOWN	ROAD	- PIK	& BROS ESVILĻE	S., INC. , MD 21208	
of the same of the	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	ly one cause on e	ach line.	nng	er the mod			ardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death	
68760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	or as a consequ										
P.O. Box 6	at the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live b	come pf pregnai irth 2  Fetal ant at time of de own	death 3	]Ectopic pro ] Other <i>(sp</i>					236	d. Date of delive	ery Day Year	
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ion or	tending Physician: Jeath. stor: After this certific the funeral director,	tion: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date		28b. Time of Injury		Bc. Injury Work		2	8d. Describe			<i>y)</i>	
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	he Hospital or in 24 hours afte he Funeral Dir pletely filled in	ledical (	29a. Certifier (Check only one) 1 Certifying	Physician: To the aminer: On the ba	best of my know asis of examinat ner stated.	vledge, death ion and/or in	occurred avestigation,	at the tim in my op	ne, date and Dinion, death	place, a	and due to the ed at the time	cause(s) ar	nd manner as s lace, and due t	tated. o the cause(s)	
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State Registrar 31. Date filed (Month, Day, Year)
DEC 1, 4

sted cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) Time of Death BEN **Physician** OURT ecember 13 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner AUGSBURG LUTHERAN NURSING HOME PIKESVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1 □ M 2 👿 F 69 216-34-2609 06/01/1937 Director MARYLAND Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No GWYNN OAK Director BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3313 KERRY ROAD 21207 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) NURSE'S ASSISTANT HEALTHCARE 11TH marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is 1 and 2 should be fit. Health and Mental Fiem 27 is marked ot HILDA M. BECKETT JAMES A. STANTON ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any injury or other trau HUSBAND 3313 KERRY ROAD, BALTIMORE CO., 21207 RALPH BENTON, JR./ 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Murial 2 Cremation 3 Removal from State 12/20/06 LAUREL, MD MD NATL MEM PARK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, Enter the disease, or complications that caused the hear failure. List only one cause on each line Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, (Final Cause Physician neumoni diser or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transit ding physician and Due to (or as a consequence of): Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) detached P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? 2□No 2 No Division or Vital 25. Was case referred edical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 🔲 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury 28h. Time of 28d. Describe how injury occurred of Death 28c. Injury at Work? atural (Month, Day Year) 5 ☐ Pending Investigation 1 ∏Yes 2 ∏No death. 2 Accident the Director: 6 □ Could not be 3 ☐ Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature 29d. Date signed (Month, Day, Year) address of person who comp ause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 4 2006 Registrar

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		-	For State Registrar	State of Ma	Cei	rtificate of L			g. No.	0 3 7 1 1		
	Dharainia		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death		
	Physicia /Medic	al	Elizabeth Fr		rown			Dec. 1	3, 2006	1:20P M		
	Examin	er	4a. Facility Name (If not institution, give si		1 1.	4b. City, Town, or Westmi	Location of Death		4c. County of Death			
			Westminster Nurs 5. Social Security Number 6. Sex		Carroll							
	Funeral Director		219-28-8228  Usual Residence of Decedent	Month, Day, Dec. 11	9. Birthplace (State or Foreign Country) 1, 1928 Maryland							
	and w	}	10a. State 10b. County			10d. Inside City Limits						
	Many -f sh	ţō	MD Carroll Westminster							1 ☐ Yes 2 <b>X</b> X		
	or 28e	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Cou	ntry?		
	15 wit	alD	941 Stone Rd.				158		U.S.A.			
36	be filed within 72 hours after death with the Maryland hal hygiene. id other then "naturel", or Items 23e or 28e-f show other then "naturel", or Items 23e or 28e-f show event. The Madical Ever in et must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  X ☑ Widowed 4 □ Divorced	<ol> <li>Was Decedent I Armed Forces?</li> <li>1 ☐ Yes XXXIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII</li></ol>	No.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes XXNo	ispanic Origin? (Spe in, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: W			
21215-0036	2 hou	ted t	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Business/Ir	ndustry		
215	hin 73 9. 9n "na Me II	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	(+)		during most of worki	ng	Oran II.a			
21	filed with Hygiene Sther thei	Con	7			Homemake		(First Mindella A	Own Ho	me		
Ind	be file tal Hy doth even	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name					
Z		<sup>2</sup>	William Leon G		19h Maili	nn Address (Street			ne Kendig , City or Town, State, Zi			
Maryland			19a. Informant's Name/Relationship (Type Charles R. Brow			7 Butle			, Marylan			
	ges 1 and 2 t of Health If item 27 or other tr		20a, Method of Disposition		20h. Place of Dispo	osition /Name of		_	20c. Location - City or T			
Baltimore,	e ° = 5		XXBurial 2 □ Cremation 3 □R 4 □ Donation 5 □ Other (Specify)	emoval from State	Evergre	matory or other place en Memo	rial 12	/16/06	Finksbu	rg, MD		
	permit. Pag Department Importent: any injury once.		21. Signature of Fine and Address of Facility Eckhardt Funeral Chapel P.  120. Name and Address of Facility Eckhardt Funeral Chapel P.  11605 Reisterstown Rd. Owings Mills, MD211.									
ä	Dep Imp		1 trebuch /n	mm_	_ 11	1605 Reis	sterstow	n Rd. O	wings Mil:	ls,MD21117		
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused e cause on each i	d the death. Do not en	ster the mode of dying a charge	ng, such as cardiac c	or respiratory arre	est,	Approximate Interval Between Onset and Death		
68760,	The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate asset a fluoring Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):  n a consequence of):	lerotre	Vasca	ulm	lisene	25yr		
	artifica ing ph e as tl		IF FEMALE:									
.O. Box	he death cert the attendin thed for use	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	/		23d. Date of delive Month	very Day Year		
<u>α</u>	res that the de signed by the be detached to	by Ph	Part II. Other significant conditions cor	ntributing to death b	ven in Part I.		bacco use contribute to					
ecords,	w require been sig should b	eted						24a. Was a	n 24h Were aut	topsy findings available		
Rec	has t	Completed by						autops	sy prior to c med? death?	ompletion of cause of		
			Of little and interest to modical				26. Place of Deat		2 No 1 Yes	2 No		
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	ent 2 ER/Outpatie	ent 3 DOA	or .		ence 6 □Other (Spec	eifv)		
of	ding Phys	-	27. Manner of Death  1 2 Natural 5 Pending	28a. Date of Inju (Month, Da	ury 28b. Time	of 28c. Injur	ry at		ow injury occurred	,)		
Division	or Atten after deat Director:	Certification:	2 Accident investigation 3 Suicide 4 Homicide   Accident investigation   Marcide   See. Place of Injury - At home, farm, street, factory, office   See. Place of Injury - At home, farm, street, factory, office   See. Place of Injury - At home, farm, street, factory, office   City or Town, State)									
_	To the Hospitel or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best ner: On the basis of and manner si	of examination and/or i	ith occurred at the ti nvestigation, in my o	me, date and place, opinion, death occur	and due to the c red at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)		
	ro the vithin ro the comple	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Month			
	1		I John W. M	Willits	anni	D2	5442		12/13/20	286		
	y to		30. Name and address of person who co	ompleted cause of	death (Item 23a) (Type	p. Print)	01.	1		2		
	254		John W Mid	leton	MD 68	8 Poole	Md, W	estma	12/13/20	D4157		
	St Regist	ate rar	31. Date filed (Month, Day, Year) DEC 1 4 20	32. Jegist	rar's Signature	beeter			,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1 Per Phy G862 12/14/06 Th Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2 1

Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Arthur K. Bosley 2006 6.30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1812 Roland Ave. Ruxton Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1X M 2□ F 217-07-8011 88 Director Dec. 17,1917 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Ruxton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1812 Roland Ave 21204 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates 41 '-45' 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) N/A Custom\_Home Builder Construction permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ David E. Bosley Bessie E. Wilhelm 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1812 Roland Ave. Eugenia K. Bosley/Wife Ruxton, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ceme Dec. 16, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Upperco, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Road Timonium, MD 21093 Michael J. Flagle Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence, of): diovascular Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown s been signed by t should be detach Part II. Other significant conditions, contributing to death but not respliting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ructive ona. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 has autopsy performed? Yes 2,200 certificate 1∐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 Residence 6 □Other (Specify) funeral 27. Manner of eath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Bescribe how injury occurred After Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) certifié 29c. License number MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 16000sler DO# 210 TOWSON M140, MU

State Registrar

DHMH 17 Rev 1/2001

0157 31. Date filed (Month, Day, Year)

**DEC 1 4** 

2006

326Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6:30 P M Altha Virginia Baker December 11, 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore County Lochearn FutureCare Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 9, 1913 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 5 Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M Maryland 93 218-09-5886 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County XXYes 2 □ No N/A Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 4800 Seton Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXO If Yes, Give 11. Marital Status Never Married 2☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 white Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) In own home Homemaker 5th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Appleby John Henry Baker ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21211 3357 Chestnut Avenue Elizabeth Hershey Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bunal 2 K remation 3 Removal from State 12/13/2006 Catonsville, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service 22. Name and Address of Facility Lie Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 Part . Enter the cisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 months **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transi and Due to (or as a consequence of) physician P.O. Box 68760 Physician/Medical death certificate th, as ed by the attending I 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown The law requires that the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 ☑ No 24a. Was an autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No

certificate Hospital or Attending Physician: funeral director, this After within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Certification: To

Medical

27. Manner of Death 1 Natural 5 ☐ Pending investigation 2 Accident 6 Could not be 3 Suicide

4 Homicide 29a. Certifier

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7220 32 Registrar's Signature

and manner stated.

Avenue all Heights

State Registrar

the

			Sta 1 - State Registrer	te of Mary	land / Depa <i>Cer</i>	artment of F		Mental Hy	giene Reg. No.20	06	39714	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Eloi'se M · Bo	, d				2. Date of D Month Decem	Death Day 12 2006 540 A M			
	Examin		4a. Facility Name (If not institution, give street a 1796 Joan Avenue			4b. City, Town, o			4c. County of Death Baltimore			
	Funeral Director		5. Social Security Number 216-03-2855 6. Sex	7. Age (In 88	yrs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bi (Month, D 1 – 31 -	rth ay, Year) -1918	9. Birthplac Country	ce (State or Foreign  MD	
	Maryland f ehow	or	Usual Residence of Decedent		c. City, Town or Lo					10d.	I. Inside City Limits	
	death with the Maryland me 23a or 28a-f ehow	Funeral Director	10e. Street and Number 1796 Joan Avenue		Idikvii	10f. Zip Code 2 1 2 3 4		10g. Citizen of V	itizen of What Country?			
	- 2	by	1 Never Married 2 Married 1	s Decedent Ever ned Forces? Yes 2 2 No es, Give ar or Dates:			dispanic Origin? an, Mexican, Pu	(Specify Yes or N rerto Rican, etc.)	o- 14. Rad Blad	ce - American ck, White, etc y: Whit	C.	
0-61212	be filed within 72 hours after ital Hygiene. Id other then "naturel", or ite event, the Medical Exercite	Completed	15. Decedent's Education (Specify only highest grade comp.  Elementary/Secondary (0-12) Co.	leted) lege (1-4or 5+)	(Give	lent's Usual Occup kind of work done DO NOT use retired Homem	during most of a d)	working	16b. Kind of B		stry	
yland	A TE O	To Be C	17. Father's Name (First, Middle, Last) Unknown	Elois	e Fishe	me (First, Middle, Maiden Sumame)						
Mar	alith a		19a. Informant's Name/Relationship (Type, Pri Eric Boyd - Son	1t)				Rural Route Numb				
baitimore,	Pages 1 entent of Hearnint: if item		20a. Method of Disposition 1 ☐ Burial 2 ☼ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	I down Chate	Ob. Place of Dispo:	sition (Name of natory or other place	ce)	Date	20c. Location -	City or Town	n, State	
Dail	permit. Pages Department of I important: if it eny injury or o once.		21. Signature of Ferreral Service Libensee		22 P A	Name and Addre	willow	radley- Spring	Ashton Road	FUne	ral Home	
	Physician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	e on each line.		er the mode of dyir	ng, such as card	diac or respiratory	arrest,	A in	pproximate hterval Between Onset and Death YEAYS	
	/Medical Examiner	er	Sequentially list conditions, b	Oue to (or as a cor								
/ on' 4	ate be executed hysicien and the burial-transit	Ical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events  c	due to (or as a cor								
O. Box 68	death certific e ettending p id for use as	Physician/Med	in the past 12 months?	es, outcome of pr. Live birth 2  Pregnant at time Unknown	Fetal death 3 [	Ectopic pregnancy	<i>y</i>		1	te of delivery onth Da		
cords, P	requires thet the reen signed by th hould be detache	ک	Part II. Dther significant conditions contributing Cerebro vascular	-	-	nderlying cause giv	ven in Part I.		Did tobacco use contribute to the cause of death?  1			
Lec	aw 2 S S	Completed								opsy prior to completion of cause of death?		
VII	Physician: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospita		a 🗆 E B 10	0#	000	Death (Check only				
	Jing After fune	atlon; To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of Injury	28c. Injur		g Home 5 Res 28d. Describe	how injury occur			
DIVISION	To the Hospital or Attent within 24 hours effer death To the Funerel Director: completely filled in by the	Certification;	4   Homicide	building, etc. (Sp				City or To	(Street and Numb wn, State)			
	the Hosp in 24 hou the Fune pletely fil	ledical		To the best of my the basis of exard manner stated.	y knowledge, death mination and/or inv	estigation, in my o	ppinion, death or	ace, and due to the courred at the time	, date and place,	and due to th	ne cause(s)	
	To Too	×	29b. Signay re and title of certifier	mo	)	29c. Licens	4650	4	December 29d. Date signe	ser 12	,2006	
	\$		30. Name and address of person who complete Nancy Friedley, MD	d cause of death	(Item 23a) (Type,   Samar	itan Ho	spital	, Balti	nore, r	nD.	21239	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 4 2006	32 degistrar's S	Signature	and I						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh 9862 12-14-06 vt. State of Maryland / Department of Health and Mental Hygiene) 1 1 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2006 2:15 A M Bertha Emmeline Bubp December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** <u>Gilcrest Genisis at G.B.M.C</u> Towson Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1 ☐ M 2 💢 F Months Hours Min. Yrs. Director 85 June 12 1921 Pennsylvania <u> 205-05-7732</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 □Yes 2 □ No permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Inthortant: If Item 21 is marked outher than "natural" or items 23a or 28a-1 sh Important: If Item 27 is marked other than "natural" or items 23a or 28a-1 sh any injury or other traumatic event, the Medical Examiner must be notified. Director Maryland <u>Baltimore</u> 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 425 Hornel Street 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NA Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Moser Emmeline UNKNOWN ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ( Husband ) Wilber A. Bubp 20a. Method of Disposition <u>425 Hornel Street Baltimore,</u> Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State  $\frac{14}{1}$ , 2006 4 ☐ Donation 5 ☐ Other (Specify) Crematory Inc Baltimore, Maryland Bayview 22. Name and Address of Facility
W. Dabrowski/Chojnacki Funeral Homes P.A. 21. Signature of Funeral Service Licenses 1005 Dundalk Ave. Baltimore, Maryland 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 0 65 truct **Physician** ens /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 menths? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ KY phosis 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1□ Yes the Hospital or Attending Physician: nin 24 hours after death. the Funeral Director: After this certifice 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No 3□ DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 ☐-Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 7 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 13, 2006 1) 25 205 N. Chales St. Balto-md Zc 205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) 32. Régistrar's Signature

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		'	State Registrar					Cer	tificat	e of	Death	1		Reg		JUU	0 )	110
	44.		1. Decedent's Nan	ne (First, Middle	e, Last)								2. Date of	Death	Day		3. Time	of Death
	Physician /Medical Elsie A. Conaway								Month Dec.						13 2006 Year			5 P ™
1	Examiner 4a. Facility Name (If not institution, give street and number)								4b. City,	Town, o	r Location	of Death	4c. County of			of Death		
3 All 18			1245 Ca	rrollyn 1	Drive				Wes	stmins	ster				Ca	rroll		
	Funeral		5. Social Security I	Number	6. Sex	7. Age (II	n yrs. last bi	rthday)	If Unde		If Under Hours	r 24 Hrs. Min.	8. Date of	Birth	ear)	9. Birthp	lace (State	or Foreign
	Director		215-03-61	.53	1□M 2 <b>X</b> F		89	Yrs.	MOHUIS	Days	riouis	IVIII.	July	[4, 1	[917	Mary	land	
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			For State Registrar	State of	of Marylar		irtment of tificate of				gieņe Reg. No. ()	06	39717
			1. Decedent's Name (First, Mide							2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic		Sean C	orbin						12_	04	2006	04:00 M
A Compa	Examin		4a. Facility Name (If not institution				4b. City, Town,					unty of Death	
1			Mercy	medical	Cent	er		1+im					re Lity
	Funeral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.		If Under 1 Yea Months Day		24 Hrs. Min.	8. Date of Birt (Month, Day	v, Year)		place (State or Foreign ntry)
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	and and		Usual Residence of Decedent  10a. State 10b. Count	ly .	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Mary	ō	MD			Ra	1timore						1√ Yes 2 No
	158 150 Inc.	- C	10e. Street and Number		1		10f. Zip Code				10g. Citizen	of What Cou	ntry?
	Sa or	<u> </u>	4111 Wentworth	Road				21207				USA	
	daati	by Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13. V	Vas Decedent of Yes, specify Cu		igin? (Spe	cify Yes or No-	14.	Race - Ameri	
9	or ite	큔	1 Never Married 2 ☐ Ma	Armed F 1 Tes If Yes, G	2 1 No		_			rican, etc.)	1	Black, White,	
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Ž	d Mark Thank	၉	19a. Informant's Name/Relation	sehin (Tyne Print)		19h Mailin	g Address (Stre	et and Numh	er or Rura	I Route Numbe	r City or To	wn State Zii	Code)
Maryland	d 2 s th an 7 te r		Mercy Medical										
o,	Haal Haal em 2		20a. Method of Disposition	Center	20b. F	Place of Dispos	St. Pa sition (Name of			arcimor Date		on - City or T	
٥	permit. Pagas 1 and 2 should be filad within 72 hours aftar daath with the Marylan Department of Haatih and Mantal Hyglana. Importent: if item 27 is marked other than "neturer", or items 23s or 28s-f ehow any injury or other treumatic event, the Modical Examinar must be notified at 80ce.		1 Burial 2 Cremation	3 Removal from	State	cemetery, cren	natory`or other p	(ace)					
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o	Phys this ral di	<u>۲</u>	1 ☐ Yes 2 No 27. Manner of Death	1 140		ER/Outpatien 28b. Time of	1 3 DON	4014		me 5 Resid			(y)
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5	aftar Dire	Certification;	4  Homicide deter	build	ling, etc. (Special	(y)	•			City or Tow	m, State)		
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	withir To th	Σ	29b. Signature and title of certif	ier			29c. Lice	nse number	- 45		29d. Date sig	gned (Month,	Day, Year)
			/ 1	Ausu	1 NW			29	29	19	LZ.	104	2006
			30. Name and address of person	n who comp cau	ise of death (	n 23a) (Type,	Print)			,	- /	1/	D LILOZ
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Pearl E. Cerrato December 12, 2006 6:00 A M 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 2810 Miles Avenue Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 6 Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days Hours 23,1924 January 219-16-6345 1 □ M 2XX 82 PA Usual Besidence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD N/A Baltimore 1 Y es 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2810 Miles Avenue 21211 U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes ZYNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐ Yes 2**⊠X**o Specify. White 3€Widowed 4 □ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Leisey Louisa Hess 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Catherine Cerrato 919 West 38th Street Balto, MD (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park Cemetery Date 20a. Method of Disposition 14 Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 12/16/06 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Service Licence 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home 3631 Falls Road Balto, MD 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Acute Due to (or as a cons wence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IE ECMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? litions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 2 No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 25. Was c ck only one)

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Ex miner must be notified at

filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0036

death with the Maryland

Examine Physician/Medical þ Completed

burial-transit and sate has been signed by the attending physician page 2 should be detached for use as the buria certificate has funeral director, Be Certification: To this After t after death filled in by

The law requires that the death certificate be executed

Hospital or Attending Physician:

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Division or Vital Records, P.O. Box 68760,

23b.	Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No
	9 Unknown
art	II. Other significant cond

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Was case referred to medical			26. Place	of Death (C	heck only one)	
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3 □ DOA Other: 4 □ Nurs	sing Home	5 Residence	e 6 □Other (Specify)
Manner Death	28a. Date of Injury	28b. Time of	28c. Injury at	28d	Describe how i	niury occurred

1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide

4 Homicide

29a. Certifier

(Month, Day Year) М Place of injury - At home, farm, street, factory, office building, etc. (Specify)

escribe how injury occurred Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

29c. License number D23076

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name

Falls Red Battinene The 21211

State Registrar

Medical



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dec. 11, 2006 Year Michael ٧. Confer 12:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14308 Dairydale Road Baldwin Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 X M 2 □ F Director 203-38-2483 59 1947 Pennsylvania 16, Usual Residence of Decedent with the Maryland 10c. City, Town or Location t be notified at 10a State 10b. County 10d. Inside City Limits 1 Yes 2 No Director Md. Baltimore Baldwin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b 14308 Dairydale Road Funeral 21013 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 💆 No þ Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Senior Vice President Whiting Turner permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othin any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ray Franklin Confer Janet Dugan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Cheryl Confer/Wife 14308 Dairydale Road Baldwin, Maryland 21013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 12/13/06 Towson, Maryland 21. Signature of Funeral Service Lidensed 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, of comshock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Bety rval Between set and Death 2 45 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician at the burial-t Box 68760. as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Division or Vital Records, P.O. 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 25 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No autopsy perform 1 Yes after death.

| Director: After this certific d in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home Hospital: Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide filled 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou To the Fune completely fil and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) Charles St#210 Bactiv

State Registrar

### 06-09328 Kevin Joseph Crew

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

viii Joseph Oi		1- For State Certificate of Death Registrer		Reg No	201	06 0030
Physicia	an/	Decedent's Name (First, Middle,Last)		e of Death	Year	3) Time of Death / C
edical Exami		RCVIII GODOPII GIGII		oth Day cember 7, 2		0510 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of	Death		County of Dea	
		10306 Sunny Lake Place Apt. H Cockeysville			Baltimore Co	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Months Days Hours	24Hrs. 8. D	ate of Birth (MM	Fore	Birthplace (State or eign
Director		212-88-3177 1XM 2 F 46 Yrs Month's Days Hours		ept 26,	1960	Country) Maryland
è		10a State 10b County 10c City, Town or Location	-			10d Inside City Limits
0 W 3		0.1				1 Yes 2 X No
yłand I-f sh	햙	Maryland     Baltimore     Cockeysville       10e Street and Number     10f. Zip Code		10g. Cit	izen of What Co	ountry?
r 282	Director				TTCLA	
th the Maryland 23a or 28a-f show any notified at once.		10306 Sunny Lake Place, apt. H 21030	in? ( Specify Y	es or No-	USA 14 Race - Am	erican Indian, Black,
ath with ti items 23a	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, F			White, etc.	
er death , or iter		3 Widowed 4 Divorced If Yes, Give Year of Dates:			Specify: W	hite
rs afte ural"	þ	or Dates:  10 Page 14	ind of work do	ne 16b.	Kind of Busines	
2 hou	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	use retired)			
36 nin 7. E. than	혈	n/a Admissions Represer	ntative		Educa	ation
5-0036 led within 72 hou Hygiene. other than "nat	5   5	17. Father's Name (First, Middle, Last)  18 Mother's	s Name (First,	Middle, Maider		
215 be file ntal Hy rked o	B B	Lawrence B. Crew Mary	У	М.		Hovermale
D 21215-0036 shours after death with the Maryland and Mould Hygiew with 172 hours after death with the Maryland and Mula Hygiew "7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	2	19a Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number)	ber or Rural R	oute Number, C	City or Town, Sta	ate, Zip Code)
MD 1d 2 sho alth and m 27 is		Stephen M. Crew/Brother 2067 Ingleside Cou		rofton,	MD 21	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 permit. If then 27 is marked other than Important: If item 27 is marked other than injury or other traumatic event, the Medical		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c.	Location - City	or Town, State
Baltimore, permit. Pages I ar Department of Hes Important: If ite injury or other tr		1 A Buriai 2 Cremation 3 Renoval Iron State	12/11/	06 F	arkvill	e,Maryland
Baltir permit. P Departme Importar		22 Name and Address of Facility	,			
Dep Per Injury		Bryan W. Clary  Lemmon Funeral 10 W. Padonia F	Road, '	Timoniu	n. MD 2	<u> </u>
Physician	Г	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca	ardiac or respi	ratory arrest, sh	ock, or heart	Approximate Interval Between Onset and
/Medical		failure List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive atherosclerotic Cardiovescule)	ar Disse	190		Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):				
		Seguentially list conditions, b				
	e l	if any, leading to immediate Due to (or as a consequence of):				
	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
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exe lan	1 75	M UNPENDED #23a, 27 per ME, G863 1/9/07 TT				
760, icate be en physiciar the burial	1 8	IF FEMALE: 23c. If yes, outcome of pregnancy		23	3d. Date of deliv	*
687 ertific	an/	23b Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic	pregnancy		Month	Day Year
Box 68: death certifi the attending of for use as	/sician/	4 Pregnant at time of death 5 Dther (Specify) 1 Yes 2 No 9 Unknown 9 Unknown				
he de hed f			art I. 2	23e Did tobacco	use contribute	to the cause of death?
P.O. Es that the d	2			1 Yes 2	No 3 P	robably 4 🗸 Unknown
ords, P.C. w requires that us been signed be should be deta	1		- 2	24a. Was an		autopsy findings available
Cord law ret has be				autopsy performed?		to completion of cause of ?
of Vital Records, ag Physician: The law requin viter this certificate has been s meral director, page 2 should be	Completed		1		No 1 🗸	Yes 2 No
	8	25. Was case referred to medical 26. Place of Death (				
on of Vital Bending Physician: sath or: After this certifithe funeral director,	ا (	1 V Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4	Nursing Hon	ne 5 Resid	ience 6 🗸 Ot	her. Scene
	;	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 X Natural 5 Pending		Describe now if	ijury occurred	
ior trend death ttor:	}	Natural 5 Pending 1 Yes 2 Accident Investigation	-	101		David David Marshay City
Division tal or Attendins after death al Director:	1	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc		Location (Street or Town, State)	and Number or	Rural Route Number, City
Divis Hospital or A 24 hours after Funeral Directely filled in b	Cortification.	4 Homicide determined (Specify)				
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	2	2 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla (Check only) one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occ	ace, and due t courred at the	o the cause(s) a time, date and r	and manner as s lace, and due to	stated. o the cause(s)
To the Howithin 24 Por To the Function Completely	Modical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated				Month, Day, Year)
->-0	1 2	1		1		
		January Prutherly, MI) O.C.M.E.		De	ecember 8, 2	
		30. Name at Jack sees of person who completed cause of death (Item 23a)	ante MD 0	1201		
		Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltim	npre, MD 2	1201		
	Stat	115 1 7 7 7 1016 1 100 100 100 100 100 100 100 100				
Regi	stra	DEO I # 5000   BOSON 10.				

State of Maryland / Department of Health and Mental Hygien [ ] [ ] [ Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4:30P.M 11,2006 December Patrick Cumberland Gordon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Brooklyn 3706 West Bay Avenue Baltimore City | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept8, 1937 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 12 M 2□ F 69 Yrs. Maryland 217-32-8192 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f ehov the Medical Exeminer must be notified at 1X Yes 2 □ No Completed by Funeral Director Baltimore City Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after deeth with to nent of Health and Mental Hygiene.
ant: If item 27 is marked other then "netural", or items 23a or 2 ary or other traumatic event, the Medical Externitive must be not 21225 3706 West Bay Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 € Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+) Home Improvement Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Roger Cumberland Rose Uble 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3706 West Bay Avenue Baltimore, Md. Gordon P. Cumberland, Jr. 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 12/15/06 Baltimore, Maryland Loudon Park Mem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilita CZOTOWS K1 Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Ave. Baltimore, Md 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -IRMHOIS **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine physicien and s the burial-transit The law requires thet the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 4 Pregnant at time of death Records, P.O. 9 ☐ Unknown s been signed to should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 XNo Division of Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one | Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ☐ ER/Outpatient 3 ☐ DOA ဥ this After thi funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. spital or Attendii ours after death. neral Director: A filled in by the fu investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MX HSHOK K CHATTERJEG 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 4 2006

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

06-09445 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Yelena Chatskaya 1- For State Certificate of Death Registrar 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ December 11, 2006 1124 hrs Medical Examine YELENA CHATSKAYA 4b. City, Town, or Location of Death 4a Facility Name (if not institution, give street and number) 4c. County of Death **Baltimore County** Pikesville 1723 Reistertown Road 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 5. Social Security Number **Funeral** Foreign Months Days Director CountryKAZAKHSTA 213-37-0655 40 06/30/1966 1 M 2 X F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Yes 2 X No BALTIMORE BALTIMORE MD 28a-f shov Director 10g. Citizen of What Country? 10e. Street and Number 118 HAWTHORNE AVENUE 21208 USA Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 2 X No 4 X Divorced Widowed 1 Yes 2 X No specify: WHITE 2 16a Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) and 2 should be filed within 72 Tealth and Mental Hygiene MEDICAL BILLER MEDICAL marked other tice went, the Med 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ginzburg Be GRIGORIY GOLOVCHINER MARIA <del>GINZBURY</del> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ပ္ S 118 HAWTHORNE AVENUE - BALTIMORE, MD 21208 MARIA GOLOVCHINER / other traumat MOTHER 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Important: injury or oth ARLINGTON CHIZUK AMUNO 12/13/2006 BALTIMORE, MD Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licens SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, Physician failure. List only one cause on each line Between Onset and /Medical Death a Asphyxia Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical x AMENDED 18 per fh g862 12-14-06 vt UNPENDED Box 68760 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy the t 23b Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death Month past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown Unknown n signed by t. contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? certificate has performed' 1 🗸 Yes ✓ Yes 2 ne Hospital or Attending Physician: T n 24 hours after death ne Funeral Director: After this certifica letely filled in by the funeral director, pa 25. Was case referred to medical 26 Place of Death (Check only one) Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) FOUND: 28d Describe how injury occurred 28b. Time of Injury 28c. Injury at Work Manner of Death Deceased put head in bag with helium FOUND Natural 1 Yes 2 ✔ No 5 Pending Dec 11, 2006 1110 hrs Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State) 1726 Reistertown Road, Pikesville, MD determined (Specify) Hotel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal (Check only one) To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 Medi and manner stated

Susan Hogan MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) State Registrar 2006

certif

dress of person who completed cause of death (Item 23a)

29b. Signature and

ORIĞINAL

29c License numbe

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

December 12, 2006

			For Amend Item	23a, IVe per Dr	H, Ce	atment of briting	lealth and Me <b>06dhb</b> Death	ental Hyg	giene 006	39723
	Physicia		1. Decedent's Name (First, Middle, L	ast)		-		2. Date of Dea Month	nth Day Year	3. Time of Death
	/Medic	al	LOSSIE  4a Facility Name (If not institution, g	Chapman		4h-City Town o	r Location of Death	12	4c. County of De	os pm "
	Examin	er	4a Facility Name (If not institution, g	Missingle	ME	RANDA	16 trun		ROH	IMPRE
€,	Funeral	alle on	5. Social Security Number 6.	Sex 7. Age (in yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Yearl 9. B	irthplace (State or Foreign
*	Director	¢	215-09-4484	10 M 20 F 45	Yrs.	Months Days	Hours Wills.	+-16	-1911 2	· Chrolina
	pug *		Usual Residence of Decedent  10a. State  10b. County	10c. Ci	ty, Town or Lo	ocation		1		10d. Inside City Limits
	ath with the Maryland 23a or 28a-1 show	ъ	Rary low BAlti	WALE K	24101	11stown				1 □ Yes 2 🕶 0
	the P	rect	10e. Street and Number	Road	-11-11	10f. Zip Code			10g. Citizen of What 0	Country?
	h with	Funeral Director	3704 Field	sting Way		21	133		USA	
	8 25	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H	lispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No-	14. Race - An Black, Wh	
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5-0036	72 hours		Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates:	16a, Dece	dent's Usual Occup	pation		16b. Kind of Busines	s/Industry
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Maryland	s 1 and 2 should f Health and Men item 27 le marke other traumatic		19a. Informant's Name/Relationship	/			4 / -		r, City or Town, State	Zip Code) 3//33
	1 and Health em 27 ther t	1	20a. Method of Disposition	20b.	370 Place of Dispo	sition (Name of		ite	20c. Location - City of	or Town, State
Baltimore,	e = 5		1) Burial 2 ☐ Cremation 3	☐Removal from State	cemetery, cre	matory or other pla 1744 Censel	CO)	11-06	Brookly 2	
Ħ	permit. Pag Department Important: any injury once.		4 □Donation 5 □Other (Special Signature of Funeral Service Light	119	21	2. ame and Addre	ss of Facility CN	NOV 12	- Nomis	From Home
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			23a. Part1. Enter the disease, or co shook or heart failure. List on	mplications that caused the dea	th. Do not en	ter the mode of dyi	ng, such as cardiac or	respiratory ar	rest,	Approximate Interval Between
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Box	h cer andin use	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		∃Ectopic pregnanc	v		23d. Date of d	
	death	sicia	in the past 12 months? 1 Pyes 2 No	4 Pregnant at time of		Other (specify)	,		Month	Day Year
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3ec	The law cate has t page 2 s	μp						24a. Was autop perfor	an 246. were psy prior t rmed? death	autopsy findings available o completion of cause of ?
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₹	Attending Physician: r death. ector: After this certifics by the funeral director, p	To Be	examiner?	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Ot	26. Place of Death		ne) denœ 6 □Other (S)	necify)
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io	ttending I death. ctor: After y the funer	atio	1 Accident 5 Pending investigation	tion	injuty		Yes 2 □ No			
Division of	I or Attendater death Director:	Certification:	3 Suicide 6 Could no 4 Homicide determina		nome, farm, st	reet, factory, office	2	8f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number.
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1	Hospita 24 hours Funeral etely filled	Medical		Physician: To the best of my kn aminer: On the basis of examin and manner stated.						
	To the Hospital within 24 hours at To the Funeral I completely filled	Mec	29b. Signature and title of certifier	and manner states.		29c. Licen	se number		29d. Date signed (Mp	nth, Day, Year)
	H 3 H 5		Have	ale'		D25	112_		12/08/	2006
	(2)		30. Name and address of person when		om 23a) (Type			101 B		
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1.3	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	A		J		
4	Regist	rar	DEC 1 4 200	10 Wales St	184					

**Physic** /Medi Exami

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at angree.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Please Type or Print in B				•	•	···		
	State of Maryland State of Maryland State Amend item#5, perFH, G862, 12/14/	% Terti	ificate of L	Death			6 39724		
an cal	1. Decedent's Name (First, Middle, Last)  SAMUEL J. DUNNOCK				2. Date of De Month DEC.	Day Ye 08 2006	3. Time of Death 2:20 A		
er	4a. Facility Name (If not institution, give street and number)  SINAI HOSPITAL OF BALTIMOI		4b. City, Town, or $\mathbf{BALTI}$	Location of Deat		4c. County of E			
	5. Social Security Number 6. Sex 7. Age (In yrs. 1) 20-10-6832 7. Age (In yrs. 1) 9.2	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	ay, Year)	Birthplace (State or Foreign Country) ARYLAND		
	Usual Residence of Decedent  10a. State 10b. County 10c. City	, Town or Loca	tion				10d. Inside City Limits		
ctor	MD N/A E	BALTIMO	ORE CIT	Y			1 XYes 2 No		
Director	10e. Street and Number		10f. Zip Code	207		10g. Citizen of What	Country?		
Funeral	5626         STONINGTON AVENUE           11. Marital Status         12. Was Decedent Ever in U.	S. 13. Wa	as Decedent of Hi res, specify Cuba	207 spanic Origin? (S	Specify Yes or No	USA 14. Race - A	merican Indian,		
y Fur	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	Specify: E	Vhite, etc.						
Completed by	Specify: BLZ    Specify: BLZ   Spec								
plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life. DC	nd of work done of NOT use retired	, ,	orking		RN STAINLESS		
Con	12TH	STI	EEL WOR		mo (First Middle	STEEL  a. Maiden Surname)	CORPORATION		
Be C	17. Father's Name (First, Middle, Last)  DANIEL DUNNOCK				IE KEEN	,,			
2	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	Address (Street &			per, City or Town, Sta	te, Zip Code)		
	DANIEL H. DUNNOCK / SON			DALE R			MD 21207		
	1 XBurial 2 □Cremation 3 □Removal from State		atory or other plac		Date / 16 / 06	20c. Location - City			
	21. Signature of Properal Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207								
	Mulling 8. Pour			ERTY H	EIGHTS	AVE, BAI			
	23a. Par Ener the discusse, or complications that caused the dear show, or heart foure. List only one cause on each line.	o not enter	the mode of dyin	g, such as cardia	ac or respiratory a	arrest,	Approximate Interval Between Onset and Death		
	Immediate dause (Final disease condition resulting in death)  a. Due to (or as a consequence)		may	Vasculan	. Mya	se	Years		
ı	Cardio	YUP4H	hy		Years				
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	unce of):	)						
xaminer	Cause (Disease or injury that initiated events c	uence of):							
sal E	C <sub>d</sub>								
Media	IF FEMALE:								
lan/	23b. Was decedent pregnant in the past 12 months?	ideath 3⊟E	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year		
nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown								
by Pi	Part II. Other significant conditions contributing to death but not res	ulting in the und	lerlying cause give	en in Part I.			te to the cause of death?		
ted	Myrythrsion						Probably 4. Hunknown		
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Live birth 2   Fetal death in the past 12 months? 4   Pregnant at time of death 9   Unknown 9   Unknown 9   Unknown 9   Unknown   23d. Date of delivery   Month Day Year									
25. Was case referred to medical examiner? 1   Yes   2   Yes   2   Yes   2   Yes   1   Inpatient   2   Yes   2   Yes   1   Inpatient   2   Yes   1   Inpatient   2   Yes   1   Inpatient   2   Yes   1   Inpatient   2   Yes   Inpatient   3   Yes   1   Inpatient   3   Yes   Yes   Inpatient   3   Yes   Yes   Inpatient   3   Yes   Y									
									27. Manner of Death  1 ■ Natural 5 □ Pending (Month, Day Year)
27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury M Day Year)  28b. Injury at Work? 1 Yes 2 No  28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Yes 2 No  28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Inj									
								Mec	29h Signature and title of certifier
	ture her my		24	3152		December	12, 2006		

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sturn miller 1838 Offers TT Steven 31. Date filed (Manth, Day, Year) 2006

32 Registrar's Signature

parte

Bulto

21708

20

N 135

			1- For Amend item#8. State of Maryland / Department of Health and Mental Hygiene 2006 39725
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year 1676 M  2. Date of Death Month Day Year 1676 M
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. Country of Death  4d. Coun
	Funeral Director		Usual Residence of Decedent
	Sa-f show	Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 No
	e 23a or 2		4701 Duncannon Road 21208 USA
920	72 hours after death with the Maryland "naturel", or Iteme 23a or 28a-f show idical Evandiner must be motified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amped Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Yes 2 No lif Yes, Sive Year or Dates: 15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race - American Indian, Black, White, etc. 17. Specify: Speci
Maryland 21215-0036	na artic	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry
land 2	be filed ital Hygi id other event, I	To Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  John Henry Daviels  18. Mother's Name (First, Middle, Maiden Surname)
	s 1 and 2 should if Health and Mer Itam 27 le marke other traumatic		19a. Informant's Name/Relation hip (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  4701 Duncange Rd Pilabuill MD 21208
Baltimore,	Page: nent o ant: If ury or		20a. Method of Disposition  1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  A r Dutus  12 9-2006 First Indian
Balt	permit. Pag Department Important: I eny Injury o		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Valuating C. Greens  22. Name and Address of Facility Valuating C. Greens  23. Name and Address of Facility Valuating C. Greens  24. Name and Address of Facility Valuating C. Greens  25. Name and Address of Facility Valuating C. Greens  26. Name and Address of Facility Valuating C. Greens  27. Name and Address of Facility Valuating C. Greens  28. Name and Address of Facility Valuating C. Greens  29. Name and Address of Facility Valuating C. Greens  20. Name and Address of Facility Valuating C. Greens  20. Name and Address of Facility Valuating C. Greens  21. Name and Address of Facility Valuating C. Greens  22. Name and Address of Facility Valuating C. Greens  23. Name and Address of Facility Valuating C. Greens  24. Name and Address of Facility Valuating C. Greens  25. Name and Address of Facility Valuating C. Greens  26. Name and Address of Facility Valuating C. Greens  27. Name and Address of Facility Valuating C. Greens  28. Name and Address of Facility Valuating C. Greens  29. Name and Address of Facility Valuating C. Greens  29. Name and Address of Facility Valuating C. Greens  20. Name and Address of Facility Valuating C. Greens  20. Name and Address of Facility Valuating C. Greens  20. Name and Address of Facility Valuating C. Greens  20. Name and Address of Facility Valuating C. Greens  20. Name and Address of Facility Valuating C. Greens  20. Name and Address of Facility Valuating C. Greens  20. Name and Address of Facility Valuating C. Greens  20. Name and Address of Facility Valuating C. Greens  20. Name and Address of Facility Valuating C. Greens  20. Name and Address of Facility Valuating C. Greens  20. Name and Address of Facility Valuating C. Greens  20. Name and Address of Facility Valuating C. Greens  20. Name and Address of Facility Valuating C. Greens  20. Name and Address of Facility Valuating C. Greens  20. Name and Address of Facility Valuating C. Greens  20. Name and Address of Facility Valuating C. Greens  20. N
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition  A V tey D S CASE
	/Medical Examiner	_	resulting in death)  Due to (or as a donsequence of)  Sequentially list conditions.  Due to (or as a consequence of)
	te be executed ysician and ie burial-translt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):
68760	<u>~</u> ~ <u>~</u> •	cai	d
P.O. Box	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th	Physiclan/Med	1F FEMALE:     23c. If yes, outcome of pregnancy     23d. Date of delivery       23b. Was decedent pregnant in the past 12 months?     1 □ Yes 2 □ No     1 □ Yes 2 □ No     4 □ Pregnant at time of death 9 □ Unknown     5 □ Other (specify)
	w requires that been signed by should be deta	ል	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
Il Records,	: The law requirete has been page 2 should	Completed	24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No
of Vital	Physiclan: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1   Yes 20 No   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)
on of	Attending Physic death. sctor: After this by the funeral di		27. Manner of Death  1
Division	al or Attendi after death. I Director: A d in by the fu	Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funaral Director: After this certificete his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.
	To th withir	W	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  100633/8  29d. Date signed (Month, Day, Year)
o	2 '		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Scott Dickson Northwest North 5401 Old Court Ld. Rand Allitum MD 21133
	Sta Regist	ate rar	31. Date filed (Month DEC 1 4 2006 32. Figure 15. Lower 15.

DHMH 17 Rev 1/2001

		·	1 - For State Registrer	State of Marylan		artment o			Reg. No.	39726
	Physici /Medi		1. Decedent's Name (First, Middle, La NOLMA DU	RHAM				2. Date of De Month X CC CC	Day Year	3. Time of Death
}	Examir Funeral	ner	4a. Facility Name (If not institution, given the control of the co	lical Cult  7. Age (In yrs. 1	• • • • • • • • • • • • • • • • • • • •	4b. City, Tow If Under 1 Ye Months Da		ure		h /a hplace (State or Foreign untry)
	Director		Usuel Residence of Decedent	□M 20F (03	Yrs.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2/19/4	3 Wash	ington D. C.
	e Marylar 3a-f show	ctor	10a. State 10b. County  Md Baltim		, Town or Lo  Dunda					10d. Inside City Limits 1 ☐ Yes 2 🔼 No
	with th	Dire	10e. Street and Number			10f. Zip Cod			10g. Citizen of What Co	untry?
	ns 234	erai	6723 Railway Ave	12. Was Decedent Ever in U.	S   13 1		1222	in? (Specify Yes or No.	USA - 14. Race - Ame	rican Indian
920	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Dept inner of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show important: if item 27 is marked other than "natural", or items 23e or 28e-f show any njury or other traumatic event, the Mudical Examples outs to collisis at another.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:		f Yes, specify C		in? (Specify Yes or No- Puerto Rican, etc.)	Specify:	
Maryland 21215-0036	72 ho	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece	ient's Usual Oc kind of work do	cupation one during most tired)	of working	16b. Kind of Business/	industry
12	within ane. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>00 NOT us</i> e <i>r</i> e .emaker	tired)		Home	
д 5	i Hygi other	Becc	17. Father's Name (First, Middle, Last		11011	emaker	18. Mother	's Name (First, Middle,		
/lan	Menta Menta prked stic ev	To B	Marion N. Bryan	t			Vio	la L. Mill	s	
Jan	12 sho		19a. Informant's Name/Relationship (						er, City or Town, State, 2	
	1 and Health em 27 Ither t	١.,	Benjamin Russell 20a. Method of Disposition	/ Son 20b. P		Roberts sition (Name of natory or other		undalk , M.	aryland 212 20c. Location - City or	
ğ	ages ant of nt: If it y or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia	JEGINOVALIONI SIAIG		natory or other rk Ceme	etery 1	2/13/06	Baltimore,	
Baltimore,	pertmit. P pertmit portar y njur		21. Signature of Funeral Service Lice		22	. Name and Ad			rk Funeral	
<u>~</u>	Dep Impo		1/2						re, Marylan	
<b>)</b>	Physician /Medical		23a. Part 1. See The disease, or complete, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on each line.  a	)	er the mode of	dying, such as c	ardiac or respiratory ar	rrest,	Approximate Interval Between Onset and Death
3760, S	rate be executed to the burial-transit to th	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence)						
P.O. Box 68	Attending Physician: The law requires that the death certificate be executed in death.  •ctor: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do	death 3	Ectopic pregna Other (specify			23d. Date of deli Month	very Day Year
	quires that n signed b	٥	Part II. Other significent conditions of		ulting in the u	nderlying cause	given in Part I.		obacco use contribute to	the cause of death?
Division of Vital Records,	The law require ite hes been siç age 2 should b	Completed	Dic	ibeles, Typ	e 11				an 24b. Were au prior to commed? death?	topsy findings available completion of cause of
<u>ita</u>	ortifice ctor, p	Bec	25. Was case referred to medical examiner?				26. Place	of Death (Check only o		
<u>ح</u>	Physic this ce at dire	2	1 ☐ Yes 2 ☐ ₩6		ER/Outpatier	3 DOA			dence 6 Other (Spec	ufy)
ouo	ding P. After funer	tion	27. Manner of Death  1. Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		njuryat Work? I∐Yes 2∐N		now injury occurred	
Divisi	를 를 들	Certification;	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	B 290 Bloom of this st. At he	me, farm, str				Street and Number or Ru vn, State)	ral Route Number,
	he Hospital n 24 hours e he Funerel I pletely filled	edicai	29a. Certifier + Certifying Pl (Check only 2 Medical Executione)	nysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, deatl tion and/or in	n occurred at the	e time, date and ny opinion, death	place, and due to the o	cause(s) and manner as date and place, and due	stated. to the cause(s)
)	To the within 2 To the complet	M	29b. Signature and title of certifier	ULD		1 .	ense number		29d. Date signed (Month	
_	V		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print) Paul	ST.		e 2120	
	St: Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	7-00-			•	

DHMH 17 Rev 1/2001

		4	For Stete Registrer	State of Maryland / I	Department of Health and Certificate of Death		ene2006	39727
	Physicia		1. Decedent's Name (First, Middle, Last)	and a .		2. Date of Death	Day Year	3. Time of Death 9:10PM
	/Medic Examin	al	1-Va lee 4a. Facility Name (If not institution, give:	EldRidge street and number)	4b, City, Town, or Location of D	Dec	4c. County of Deal	
			Merry Medical ( 5. Social Security Number 6. Sec	7. Age (In yrs. last bi	inthday) If Under 1 Year   If Under 24	Hrs. 8 Date of Righ	N/ F	hplace (State or Foreign
H	Funeral Director	3		M 200 50		Hrs. 8. Date of Birth Min. ALIG 23	1956 9	Maryland
	yland	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Toy				10d. Inside City Limits
	the Mar 28a-fel	Director	10e. Street and Number	A CO	A Itimore  101. Zip Code	10/	g. Citizen of What Co	1.2 Yes 2 No
	23a or	a Dir	530 F.f. H	& Street	21227		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show all pluty or other traumatic event, the Madical Exertaine must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No ff Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, P  1 □ Yes 2 ▼ No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	in 72 hou	Completed t	15. Decedent's Edu (Specify only highest grad	cation 16a e completed)	a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)		6b. Kind of Business	Andustry
	filed with Hygiene. other than		Elementary/Secondary (0-12)	Colfege (1-4or 5+)	CAre Provide	Name (First, Middle, M.	Jeff ~	1,0920
land	ould be fi Mental H Marked oti hatic ever	To Be	Keneth E	Wridge	MA	1	own	
Maryland	nd 2 sho lith and h 27 le ma r trauma		19 Informant's Name (Pelationship (T)	(Coysin) 19	b. Mailing Address (Street and Number of	r Rural Route Nuffiber,	City or Town, State, .	Zip Code)
altimore,	Pages 1 and intention of Health int: If Item 27 iry or other tr		20a. Method of Disposition  1 Method of Disposition  1 Method of Disposition  2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Removal from State	of Disposition (Name of ery, crematory or other place)	2-15-06 2	On Location - City or	Town, State
Baltir	permit. Pages 1 Department of H Importent: If Ite eny Injury or ot once.		21. Sign Mure of Funeral/Servins Cicens	7.10.	22. Name and Address 1 Extility	more, M	Brown,	R. FHOME
			shock, or heart failure. List only o	ications that caused the death. Do ne cause on each line.	not enter the mode of dying, such as car	rdiac or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence				
۱	Examiner	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence				2 weeks
$\sqrt{}$	executed in and iet-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Utenne s	arcoma			
8760,	cate be executed physician and the buriet-transit	dicai Ex	resulting in Gealth, Last	Due to (or as a consequence	s or):			
9	entificat ding physe as th	/Medi	IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of de	livan
P.O. Box	that the death certificed by the attending properties as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetel deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 □Ectopic pregnancy 5 □ Other (specify)		Month Month	Day Year
	8 G 6	þ	Part fl. Other significant conditions co	ntnbuting to death but not resulting	in the underlying cause given in Part I.			o the cause of death?
Records,	e law has to	Completed				24a. Was an autopsy perform	ed? death?	utopsy findings available completion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other	Death (Check only one		
n of	ng Phya fter this ineral di	on: To	1 ☐ Yes 2 ☐ No  27. Mann of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of fnjury (Month, Day Year)	Time of Injury Work?	ng Home 5 🗆 Resider		ecity)
Division of	or Attending after deeth. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	M 1 Tyes 2 No		eet and Number or R State)	ural Route Number,
	Hoepital 4 hours a Funeral tely filled	edical Ce	29a. Certifier 1 Gerti ying Phy (Check only one) 2 Medical Exam	raician: To the best of my knowled iner: On the basis of examination a and manner stated.	gal death contured at the time, date and pandor investigation, in my opinion, death	Jans, and due to the na occurred at the time, da	usa(s) and manner a ite and place, and du	s stated. e to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Mon	th, Day, Year)
•	1		30, Name and address of person who o		1) (Type, Print)		sec 1 h	06
	of		Komine Thon	nas 301 St. 1	Paul Place Ba	Itmene	MD 2	1202
	Sta Regist		31. Date filed (Month, Day, Year)  DEC 1 4 20	32/Registrar's Signature	Aprile			

			For State Registrar	state of Mary		partment ertificate			Mental Hy	giene	4000	39728
			1. Decedent's Name (First, Middle, Last)						2. Date of De	eath Day	y Year	3. Time of Death
52017	Physicia /Medic		Anneliese Marie	Pesold	Echard				Decemb	_ `		0700 ™
	Examin		4a. Facility Name (If not institution, give stre			4b. City, To	own, or l	Location of Dea	th	4c.	County of Dea	th
			Upper Chesapeake M	edical Ce	nter	Bel	Air				arford	
	Funeral		5. Social Security Number 6. Sex	7. Age (li	n yrs. last birthd	Months	Year Days	If Under 24 Hr. Hours Min		rth ay, Year)	9. Bir	thplace (State or Foreign ountry)
	Director		512-38-2893	7	9 Yrs				May 5,	192	7 Bav	aria Germany
	and w	-	Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or	Location						10d. Inside City Limits
	Aaryl feho	5	Maryland Harford		Towns							1 ☐ Yes 2€ No
	28a-1	ect	Maryland Harford  10e. Street and Number		Joppa	10f. Zip 0	Code	-		10a, Cit	izen of What C	ountry?
	with a or	<u></u>										,
	leath	era	819 Old Joppa Road	Was Decedent Eve	r in U.S. 1		085 nt of His	panic Origin? (	Specify Yes or Norto Rican, etc.)	o- US	14. Race - Ame	
(0	riter of	Funeral Directo	1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 🔯 No					rto Rican, etc.)		Black, Whi	te, etc.
33	al', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2	No.	Specify:			Specify:	White
9	72 ho	Completed	15. Decedent's Educati (Specify only highest grade of	ion ompleted)	16a. De	cedent's Usual ive kind of work	Occupat	tion	orkina	16b. K	ind of Business	
21	thin 9	n di	Elementary/Secondary (0-12)	College (1-4or 5+)	lif	e. DO NOT use	retired)		9			
2	ygier ygier t. bi	Co		4	Exe	cutive )				Leg		
OB	be fill tal H d oth	Be	17. Father's Name (First, Middle, Last)	D11					me (First, Middle			
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or items 23a or 28a-f show eumatic event, the Medical Examinar must be netitied at	ဥ	Johann Leonhard		405.14	-111 4 4 4 4			tha Luc			
Zar Z	12 sh h and 7 ie m		19a. Informant's Name/Relationship (Type, Robert L. Echard /						iural Route Numb Joppa, N			ZIP Code)
0.	1 end 1eelth 1eelth 1m 27		20a. Method of Disposition		20b. Place of Di			roau,	Date		ocation - City or	Town State
Ö	or of		1 Burial 2 Cremation 3 Rem		cemetery, o	crematory or oth	er place					
Baltimore	t. Pa		4 Donation 5 Other (Specify)		Ariing	ton Nat:					ington,	Virginia
Bal	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Important: if Item 27 ie marked other then "natural", or iteme 23a or 28a-1 ehow eny injury or other treumatic event, the Madical Examinar must be notified at once.		21. Signature of Funeral Service Licensee	Pour	1	McComa:	s Fu	neral H	iome, P.A	A		
	40104		23a. Part1. Enter the disease, or complicat		debth Do not	1317 Co	okes	bury Ro	ad, Abir	ngdor	Mary	and 21009 Approximate
			shock, of figart failure. List only one	cause on each line.	death. Do not	enter tre mode	or dying.	, such as cardie	ac or respiratory a	111051,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	aeshe	city	Julle	e					
	/Medical Examiner		rodding in dodiny	Due to (or as a co	onsequence of):		1					
		-	Sequentially list conditions, b	Due to (or as a co	onsequence of	tibre	es	<u>U</u>				
-	led led	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 (0) 00 00	011304301130 90							
9 !	xecu end	Examiner	that initiated events c resulting in death) Last	Due to (or as a co	onsequence of):							
// <i>o</i> /c 8760.	ate be executed hysicien end the burial-trensit	ical E										
- 10	ficate phys		Q									
∠/ Box 6	certi nding use a	Š	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of p		_					23d. Date of de	livery
ă	death ette	ciai	in the past 12 months?	1 ☐Live birth 2 ☐ 4 ☐ Pregnant at tim		3 ☐Ectopic pre 5 ☐ Other (spe					Month	Day Year
_0	the c by the	hys	9 Unknown	9□ Unknown					,			
o <b>□</b>	wrequires thet the death certifica been signed by the ettending ph should be detached for use as t	by Physician/Med	Part II. Other significant conditions contril	outing to death but n	ot resulting in th	e underlying car	use giver	n in Part I.	23e. Did	tobacco (	use contribute t	o the cause of death?
ર્જ્	an sig		ante reint for	live					10	Yes 2	□No 3□P	robably 4 Unknown
700	s bee	jet	CVA						24a. Was		24b. Were a	utopsy findings available
ese Echard	The law requires that the death certific: ate has been signed by the ettending pl page 2 should be detached for use as t	Completed	CHF						auto perf	ormed?	death?	completion of cause of
ā	an: ] tifice for, p	a	25. Was case referred to medical					26. Place of De	eath (Check only		10.10.	
Σ	Physician: rthis certific ral director,	To B	examiner? 1 Yes 2 No	pital: Inpatient	2 ER/Outpa	tient 3 DOA		*	Home 5□Res		6 □Other (Spe	ecify)
. 5 2	g Ph Terth		27. Manner of Death	28a. Date of Injury (Month, Day Y			c. Injury Work		28d. Describe			
0) i	Attending r death.	atio	2 Accident investigation	(Month, Day 7	,u	М		es 2 No				
nn eli	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (	- At home, farm,	street, factory,	office		28f. Location City or To			lural Route Number,
50	tel or rs afte el Dir	Çer										
1	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier Certifying Physic (Check only one) 2 Medical Examiner	: On the basis of ex	amination and/o							
	thin 2 the mple	Med	29b. Signature and title of certifier	and manner stated	1.	29c.	License	number		29d. Da	te signed (Mon	th, Day, Year)
	with To		Daw 12.									
	16		30. Name and address of person who come	plated cause of deat	h (Itam 23a) (Tu			27)		12	CEMPS	- 15 sack
	16		DWIN S TO WAR	3 615	w pr	chal		Below	am -	2	1014	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	white .		- * * * * *				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Driver D 5 D D NN 6 5 W More Phail Bolove mo 2 1014  State Registrar  31. Date filed (Month, Day, Year)  DEC 1 4 2005											

06-09333 Michael Ford

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Certification	ate of Death	Reg. No. 2006 3072
Physician/ edical Examiner	1. Decedent's Name (First, Middle,Last)  MICHAEL DANIEL FORD		Onte of Death  Month Day Perendent Year ecember 7, 2006  Time of Death 1104 hrs
	4a. Facility Name (if not institution, give street and number) St. Agnes Hospital	4b. City, Town, or Location of Death  Baltimore	4c. County of Death N / A
Funeral Director	5. Social Security Number 219-80-3151	hday) If Under 1 Year If Under 24Hrs. 8.  Months Days Hours Min.	Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Foreign ARYLAND Country)
i e.	Usual Residence of Decedent  10a State 10b County 10c City, Town	or Location LTIMORE CITY	10d Inside City Limits 1 XYes 2 No
the Maryland a or 28a-f show tified at once.	10e Street and Number 906 KEVIN ROAD	10f. Zip Code 21229	10g. Citizen of What Country? USA
15-0036 filed within 72 hours after death with the Maryland Hygiene dother than "natural", or items 23a or 28a-f shu t, the Medical Examiner must be notified at once e Completed by Funeral Director		13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica Yes 2 No specify:  Decedent's Usual Occupation (Give kind of work	Specify: BLACK
5-0036 led within 72 hours Hygiene other than "natus the Medical Exant	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2 T H	during most of working life. DO NOT use retired)  COOK	EATON PARK HOSPITALITY GROUP
0 3 2 2 5 0			rst, Middle, Maiden Surname)  NIA FORD  Il Route Number, City or Town, State, Zip Code)
and 2 sho and 2 sho lealth and item 27 is traumati	VIRGINIA SCOTT / MOTHER 2		ate 20c. Location - City or Town, State
Baltimore, permit. Pages l ar Department of Her Important: If the injury or other tr	1 Nonation 2 Cremation 3 Removal from State MD V 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses	22. Name and Address of Facility HOWE	9/06 OWINGS MILLS, MD LL FUNERAL HOME 21207
Physician /Medical	23a/Pert Enter the disease, or complications hat caused the Seath. Do n failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac or res	Death Death
Examiner	or Indition resulting in death)  Due to (or as a consequence of):	clerotic cardiova-cular dis	0850
led misit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):		
68760, certificate be executed nding physician and use as the burial - transit		Æ, g863, 1/2/07 TT	23d. Date of delivery
Box 6876 he death certificate the attending plus as the Mysician/M	23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of death	Fetal death 3 Ectopic pregnancy  Other (Specify)	
ires that the decires that the decire signed by the ablanced for the decire of the dec		ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown  1 24a Was an 24b. Were autopsy findings available
Records, P.O. I The law requires that the ficate has been signed by t page 2 should be detache Completed by PP			24a Was an autopsy performed?  1 Ves 2 No 2 Section 24b. Were autopsy findings available prior to completion of cause of death?  1 Ves 2 No 2 No
f Vital B Physician: er this certifi ral director,	25. Was case referred to medical examiner?  1 V Yes 2 No  27. Manner of Death 28a Date of Injury 28b		
Division o  To the Hospital or Attending within 24 hours after death To the Funeral Director: After completely filled in by the funeral Operation:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, d		Location (Street and Number or Rural Route Number, City or Town, State)      to the cause(s) and manner as stated.
To the Ho within 24 To the Fu completel	(Check only 1 Certifying Physician: To the best of my knowledge, done) 2 Medical Examiner: On the basis of examination and/or and manner stated.  29b. Signature and title of certifier	r investigation, in my opinion, death occurred at the	ne time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a		December 8, 2006
Stat	20 Registrate Signature	nn Street, Baltimore, MD 21201	
Registra	DEC 1 4 2006	RIGINAL	

DHMH 17 Rev 1/2001 OCME 2006

		For	State of Marylan					Mental Hyg	•	
		1 - State Registrer	_	Ce	rtificate	of De	eath		Reg. No. ZU	06 39730
Physic		1. Decedent's Name (First, Middle, Last,	)					2. Date of Dea	Day Day 1	3. Time of Death
/Med Exami		Wilbur E. Ficke  4a. Facility Name (If ngt institution, give	street and number)		4b. City,	Town, or Loc	cation of Deal	th CCITIVE	4c. County o	of Death
		Saint Agnes 4	OSPITAL		B0	Utim	ove		1	n/a
Funera		Social Security Number     6. Security Number	1M 2□F		If Under Months		Under 24 Hrs Hours Min	(Month, Day	, Year)	Birthplace (State or Foreign Country)
Director		217-16-4034 Usual Residence of Decedent	84	Yrs.				7/22/2	22	Maryland
death with the Maryland me 23s or 28s-f show cross be notilised at		10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits
Ba-f s	Director	MD Howard		E11i	cott	City				1 ☐ Yes 2 🗷 No
with the or 2	Dire	10e. Street and Number			10f. Zip	Code			10g. Citizen of Wi	hat Country?
eath ne 23	eral	4105 Old Columbia	Pike 12. Was Decedent Ever in U.	S 13		21043	nic Origin? (9	Specify Ves or No.	USA 14 Bace	- American Indian,
filer d	Funeral	1 Never Married 2 Married	Armed Forces? 1.2 Yes 2 □ No	ł				Specify Yes or No- to Rican, etc.)	Black	White, etc.
ING KIKID-0030 be filed within 72 hours after tal Hygiene, d other than "naturel", or Ite event, the Medical Examina	l by	3 ☐ Widowed 4 🏠 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	2.2≰No S	Specify:		Specify:	White
72 h	Completed	15. Decedent's Edu (Specify only highest grad	ication le <i>completed)</i>	16a. Dece (Give	dent's Usua kind of wor	Occupation k done durin	n ng most of wo	rking	16b. Kind of Bus	siness/Industry
withir she	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		ter Pl				Stoomfit	ters Union
Hygin other	0	17. Father's Name (First, Middle, Last)	<u> </u>	Masi	er Fi		. Mother's Na	me (First, Middle,		
uld be fill dental Hy rked oth	To B	Carl Ficke					Helen	Taylor		
2 should and Men is marke		19a. Informant's Name/Relationship (T)	/ре, Print)	19b. Maili	ing Address	(Street and	Number or R	ural Route Numbe	r, City or Town, S	State, Zip Code)
e, IN 1 and 3 Health tem 27 other tra		Sharon Cruz / Nied					Balti	more, Ma		
S 6 1 1		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ F	Removal from State	lace of Dispo emetery, cre	matory or ot	ther place)		Date		City or Town, State
DEALLIMO permit. Pages Department of Importent: If i eny injury or		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens		don Pa	ark Ce	meter	y   12/	14/06 oudon Pa	Baltimor	e, Maryland
D Ped You		Eugene ( t	autro h							and 21229
		23a. Part1. Enter the disease or composhock, or heart failure. List only o	lications that caused the death							Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Respon	A.	m	est	_			Onset and Death
/Medical Examiner		resufting in death)	Due to for as a consequence	uence of:	,					20183
LAdmine		Sequentially list conditions	b. Due to (or as a consequence	rmy						
Juled Insit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	500 to (or as a conseq.	aerice oi).						
If OU, If	Exa	resulting in death) Last	Due to (or as a consequ	uence of):						
ate be expeciently be buria	Ical		d							
BOX OB  leath certificat attending phy	Physician/Med	IF FEMALE:	13a If was subsemp of second							
death cer death cer e attendin	clan	in the past 12 months?	23c. If yes, outcome of pregna 1□Live birth 2 □ Fetal 4□ Pregnant at time of de	death 3	☐Ectopic pre☐ Other (spe				23d. Date Mont	of delivery th Day Year
. 0 0 9	hysi	1 Yes 2 No 9 Unknown	9□ Unknown	Jul. 0	_ 0.1101 (apt	Jeny)				
	by P	Part II. Other significant conditions co	ntributing to death but not resi	ulting in the t	underlying ca	ause given ir	n Part I.	23e. Did to	bacco use contrit	bute to the cause of death?
HECOTOS he law requires has been signinge 2 should be	ted	Humonory	MASS					1 🗆 1	es 2□No 3	3 Probably 4 Zenkhown
aw aw	Completed	Ition 10	Chinos	1)18	love.			24a. Was autop	sy pr	ere autopsy findings available ior to completion of cause of
_ ⊨ a a		H135 10 P	emento U					1 ☐ Yes	208 No 1	eath? ☐ Yes 2 No
OT VICAL Physician: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner?	Hospitaf: 1 ∠ patient 2 □	ER/Outpatie	00 00	Other		ath Check only o		
g Phy g Phy er this eral d	I -	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		Bc. Injury at Work?	4   Nursing	Home 5 ☐ Resid	ow injury occurre	
VISION Attending r death. ector: After by the fune	atlo	1 Matural 5 Pending 2 Accident investigation	(Month, Day 1 ear)	Infury	М		2 □ No			
JIVISION Or Attending after death. Director: Afte	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st	reet, factory	, office		28f. Location (S City or Tox	Street and Number m, State)	r or Rural Route Number,
DIVI		29a. Certifier 1 Certifying Phy	sicien: To the best of my kno	wledge dee	th occurred	at the time	date and els-	and duc to the	aguag(s) == 1 =	nor an atatad
UIVISION OF  To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dir	Medical	(Check only 2 Medical Exami	and manner stated.	tion and/or in	nvestigation,	in my opinio	on, death occ	urred at the time,	date and place, ar	nd due to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier	8		29c	. License nu	ımber		29d. Date signed	(Month, Day, Year)
\		Elull	Monl			1/30	145/		12 -	11-26
12-41		30. Name and address of person who	empleted cause of death (Item	23a) (Type	Print)	11	1 4	100 (1	7 moli	10-11130
	tate	31. Date filed (Month, Day, Year)	32. hagistrar's Signa	M L	MANUE	10	inc	1 4	TUT TO	(Month, Day, Year) 11 - 26 (1 1 2 3 ) 1 2 2 8
Regis		DEC 1 4 2	006 32. Hagistran's Signa	No.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 Month Pay **Physician** 2006 4:30p M Franklin Marv /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FutureCare-Cherrvwood Reisterstown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 83 Months Days Hours Min 1 □ M 2 □XF Director 2-25-1922 <u> 18-18-2429</u> MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f sho Iner must be notified at 1 ☐ Yes 2 🛣 No Director Baltimore Randallstown 10g. Citizen of What Country? 10e. Street and Number 8 Elwell Court 21133 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status d other than "natural", or Iten event, the Medical Examiner Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No African-American Specify: Completed by 34 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Teacher 5+ Public Schools is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles C. Griffin Sr. Mary Askins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Celeste D. Franklin/Daugh. 8 Elwell Ct., Randallstown, MD 21133 27 Important: If Item 2 any Injury or other once, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 12-15-06 Cheltenham, MD Cheltenham Vet. 22. Name and Address of Facility Wylie F/H P.A. of Balto.Co. 9200 Liberty RD., Randallstown, MD 21133 Part1. Enter the diseas shock, or heart failure. dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) neamonca /Medical Due to (or as a consequence of) Examiner sea 06h Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the bunal-trans Due to (or as a consequence of): Physician/Medical 38 attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an director, page 2: autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2∏No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director:

Baltimore, Maryland 21215-0036

/dace 31. Date filed (Month, Day,

State Registrar 29b. Signature and title of certifi



25

address of person who completed cause of death (Item 23a) (Type, Print)

B

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

**Funeral** 

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must once.

the Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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24 hours after death.

e Funeral Director: After thi letely filled in by the funeral

within 2

## 06-09415 Со

olista V. Garlar		State of Maryland / Department of Health and 1-For State Certificate of Death	d Mental Hy	giene		
Physicia	ın/	Decedent's Name (First, Middle,Last)	2	2. Date of Death	No. 200	3/Time of Death / 3
ledical Examii	ner	4a. Facility Name (if not institution, give speet and number)  4b. City, Town, or	Location of Dogth	Month December	Day Year 10, 2006 4c. County of Death	1308 hrs
4		1227 Collins Avenue Odenton	Location of Death		Anne Arundel	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days		8. Date of Birth	(MM/DD/YYYY) 9. Birt	
Director	1	X3/20-/475 1 M 2XF Vrs.	s Hours Will.	July à	22 1923 CO	intry) Virginia
any		Usual Residence of Decedent  10a, State  10b. County  10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show d at once.	ē	N/d Anne Arundel Udenton				1 Yes 2 No
5-0036 led within 72 hours after death with the Maryland thygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Director	10e. Street and Number 10f. Zip Code 2/11	3	10g	. Citizen of What Cour USA	itry?
ath with	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 13. Was Decedent Ever in U.S. 14. Was Decedent of His If Yes, specify Cuban			14. Race - Ameri White, etc.	can Indian, Black,
ifter de		3 Widowed 4 Divorced If Yes Give Year 1 Yes 2 No	specify:		Specify: Bl	ack
hours a	leted by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Specify only highest grade completed)  17b. Decedent's Education (Specify only highest grade completed)			16b. Kind of Business/I	
5-0036 iled within 72 Hygiene. I other than '	Complet	7.00	Operator		Federal	Government
21215-003 ould be filed within Mental Hygiene, marked other ti	Be	John Thomas	18.Mother's Name (	/ /	Ulas	
and and mati	T <sub>0</sub>	19a. Informant's Name/Relationship (Type, Print)  Tommy Garland, SR. (Son) 1227 Collaborationship (Type, Print)		Carl III.	7"	
Baltimore, Normani. Pages I and 2 Department of Health Important: If item 2 mijury or other traum		20a. Method of Disposition  1 Bunal 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:		3-06	20c. Location – City or Ballmare	Town, State
Baltimo permit. Page Department o Important: injury or ott		4   Donation 5   Other Specify:   V   V   C   C   C   C   C   C   C   C	Bro un	JR.	Funeral 16 MS	Home
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, failure. List only one cause on each line.	such as cardiac or	respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a Dementia  Due to (or as a consequence of):		····		Death
	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	miner	cause. Enter Underlying Cause (Disease or injury that initiated				
executed an and al - transit	i Exa	events resulting in death) Last Due to (or as a consequence of):  d.				
an a	edical	UNPENDED AMENDED		-		
6876( certificate nding phys		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnan	cy	23d. Date of delivery	lay Year
Box 6876  e death certificate the attending phy ed for use as the l	sician/N	Pregnant at time of death 5 Other (Specify)				
O. B. at the de ached f	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
s, P.O ires that t signed b d be detac	d by			1 Yes	2 No 3 Prob	abły 4 Unknown
of Vital Records, ag Physician: The law requirements the three of the continuent of	Completed			24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
tal Rec ian: The L certificate F	Com			perform 1 Yes 2		s 2 No
/ital	o Be	avening?	of Death (Check or Other:  Nursing		esidence 6 🗸 Other	: Scene
_ = . ▼ . ∃ .	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury		28d. Describe ho	w injury occurred	
Division tal or Attendi rs after death. al Director: A	icati	2 Accident Investigation 28e Place of Injury - At home farm street factory office h	Yes 2 No	28f Location (Str	eet and Number or Ru	ral Route Number, City
Div pital or ours after	Certification:	Suicide 6 Could not be determined (Specify)	, sag, s	or Town, Sta		ar rodic ramber, only
ple the hin	Medical (	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, da one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and memor stated.				
To with To con	Me	29b. Signature and title of certifier 29c. Licenso			29d. Date signed (Mor	
	1	O.C.N	M.E.		December 13, 20	06
4		30. Name an address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Balti	imore, MD 212	01		
St Regist	ate rar	DEO 4 1 0000 Pr. St. Planette		-		
	_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2 Date of Death 3. Time of Death Year 05 **Physician** 04150 -2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NA MERKY Center nedical more If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ■ M 2 💢 F 6976 Yrs. 216-20-MARYIAND Director December 17,1928 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1**∀**Yes 2□No timore **Funeral Director** MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ISA 21202 926 ABBOH 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 No Specify β 3 ☐ Widowed 4 ☐ Divorced AMERICAN KICAN Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 124 WN nestic permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygies
Important: If Item 27 is marked other tt
any Injury or other traumatic event, the
once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be HellAnd 19b. Mailing Address (Street and Number or Rural Route Number, Çity or Town, Ştate, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Street BAltimore, MARY And RAKKIN VIR ginia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State DECEMBER 1 ☐ Burial 2 【Cremation 3 ☐Removal from State Vetro 2006 forsuille MARGHAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Funeral Securices Wancy m. Wallace Funeral Securices MARYLAND 2/229 3405 W. FRANKLIN Street Baltimore, MARYLAND 2/229 21. Signature of Funeral Service Licenses callace 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ciscase or irjury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical nding L se as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 ∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 1 Yes 2 No 1 Inpatient 3□ DOA Medical Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name a

mic

31. Date filed (Month, Day, Year)

nae

**DEC 1 4** 

2006

DHMH 17 Rev 1/2001

301

St Paul Place.

Baltimore

address of person who completed cause of death (Item 23a) (Type, Print)

Drasso

3. Registrar's Signature

		For S  Registrar	tate of Ma			ment of Hicate of L		nd Mental		ene <sub>2</sub> 0	06	39	735
Physici	ian	1. Decedent's Name (First, Middle, Last)  Irvin G. Hall						2. Date Month Dece	of Death		2006	3. Time o 3:50	f Death A M
/Medic Examin		4a. Facility Name (If not institution, give stre Stella Maris Hospice			Т	. City, Town, or imonium	1	Death		4c. County Balti	of Death		
Funeral Director		LIL IO STII N	2 ☐ F 7. Age	(In yrs. last birt		Under 1 Year onths Days	If Under 2	Min. 8. Date (Mont	of Birth h, Day, Y	1918	9. Birthp Cour	place (State of try) Mar	or Foreigr ^ylar
Be death with the Maryland ime 23s or 28s-f show r rules be notified at	tor	Usual Residence of Decedent           10a. State         10b. County           MD         Baltimore		10c. City, Town	n or Locatio	on					1	0d. Inside C	ity Limits
with the	Direc	10e. Street and Number 409 Alabama Road				Of. Zip Code 21204			US	. Citizen of \	What Cour	ntry?	
336 us after death us after death ut; or Neme 23	by Funeral Director		Was Decedent E Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	ver in U.S.	13. Was		spanic Origi n, Mexican, Specify:	in? (Specify Yes Puerto Rican, et		14. Rac	e - Americ ck, White, y: W		-,
21215-0036 and within 72 hours aff	Completed	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12) 12	on ompleted) Coll <b>ege</b> (1-4or 5+ 4	+)	Decedent' (Give kind life. DO I	s Usual Occupa of work done of NOT use retired	ation furing most	of working		Sb. Kind of B		,	 eeri
land 2 Id be filed to ental Hygis ked other	To Be C	17. Father's Name (First, Middle, Last) Simon Hall	·		<u> </u>			's Name (First, N e Mae Pa	iddle, Ma	iden Suman			
Maryland id 2 should be file th and Mental Hy 27 Is marked oth traumatic event	F	19a. Informant's Name/Relationship (Type, Susan Zerofsky /	Print)  daught					or Aural Aoute			State, Zip	Code)	
Baltimore, Baltimore,		20a. Method of Disposition  1 \( \Delta \text{Burial} \) 2 \( \Delta \text{Cremation} \) 3 \( \Delta \text{Rem} \)  4 \( \Delta \text{Donation} \) /5 \( \Delta \text{Other} \) (Specify)		20b. Place of cemeter	f Dispositiony, cremato	n (Name of ry or other plac	θ)	2/15/06	20	imoniu			
		21. Signature of Fluneray Sorvice Lourses	Zey/			TOWSON		ral Home		1050 York Road Towson, MD 21204			1
	dicai Examiner	shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a		of): of):	DENT						Onset and	Death
Box 6  death certifi  he attending	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of 1 Live birth 2 4 Pregnant at t	2 🗌 Fetal death		opic pregnancy ner (specify)					ite of deliver	-	Year
ds, P.O.	<u>چ</u>	Part II. Other significant conditions contrib	outing to death bu	it not resulting ii	n the under	lying cause give	en in Part I.	23e.		cco use cont	tribute to th		death? )Unknov
Records, The law requires see hes been sign	Completed								Was an autopsy performer	ed?	Were auto prior to co death? 1 \( \subseteq Yes	psy findings mpletion of	availat cause c
n of Vital ng Physician: tter this certifice	Certification: To Be (	27. Manner of Death  12 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injun (Month, Day) 28e. Place of Inju	r Year) I	Time of Injury		er: 4 ☐ Nur	28f. Loca	Residen	ce 6 Oth	red	-1100	PICE
Division  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t		29a. Certifier	building, etc.	of my knowledge	e, death oc	curred at the tim	ne, date and	I place, and due I	or Town,	ise(s) and m	anner as s	tated.	·
To the He within 24 To the Fe completel	Medical	(Check only 2 Medical Examiner one)  29b. Signature and alle of certifier	and manner stat	ted.	iwor invest	29c. Licenso	e number		296	d. Date signe	ed (Month,		5)
10		30. Name and address of person who comp	oleted cause of de	eath (Item 23a)	(Type, Prir	1 )	451	25	1	2/12/0	)6		
St Regist	ate	DR. TARIQ MAHMOOD  31. Date filed (Month, Day, Year)  DEC 1 4 2006	100	r's Signature	ALLEY	RD. J	IMONI	UM, MD 2	1093				

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar	State of Mary		rtment of F tificate of I			2006	39736
	Dhysisi		1. Decedent's Name (First, Middle, Last,	)				2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		Hedwig	Maryanne	e His	ley		December	12,2006 Year	8:05 P M
	Examin	er	4a. Facility Name (If not institution, give	street and number)		_	r Location of Death		4c. County of Dea	
			Edenwald  5. Social Security Number 6. Security Num	7 Age //n	yrs. last birthday)	TOWS	-	8. Date of Birth	Baltin	
	Funeral Director			7 aV1.e	93 Yrs.	Months Days	Hours Min.	Sept. 29	,1913 Ma	thplace (State or Foreign buntry) aryland
	land		10a. State 10b. County	100	c. City, Town or Loc	cation				10d. Inside City Limits
	Mary f • hc	ō	Maryland Baltimo	ro	Towson					1 ☐ Yes 2 🏋 No
	r 28a	rec	10e. Street and Number		1003011	10f. Zip Code		10g	. Citizen of What Co	ountry?
	th witi	Funeral Director	800 Southerly	Road #205		212	04		U.S.A.	
	dea	ner		12. Was Decedent Ever Armed Forces?	in U.S. 13. V	Vas Decedent of H	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
36	be filed within 72 hours after death with the Maryland stal Hyglene. ed other than "naturel", or flome 23a or 28a-f ehow svent, tra Mudical Exain, af must be traffie a la	by Fu	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates:		☐Yes 2♥No	Specify:	,	Specify:	lhite
Ş	2 hou	ed	15. Decedent's Edu	cation	16a. Deced	ent's Usual Occup	ation	16	b. Kind of Business	
215	within 72 ene. than "na	Completed	(Specify only highest grad	e completed) College (1-4or 5+)	(Give i	kind of work done of OO NOT use retired	during most of worki	ng		
21	e filed within at Hygiene. other than 'vent, its me	Son	12	3	Но	memaker			Own Hom	ie
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	iden Sumame)	
Maryland 21215-0036	should be nd Mental marked o	ဥ		eksinski			Hedwig		<u>ot Availa</u>	
Mai	id 2 st ith and 27 is n traun	1	19a. Informant's Name/Relationship (T)				and Number or Rura			
	Hea Hea ther		John C. Hisley  20a. Method of Disposition	Son	0b. Place of Dispos	Lobloll sition (Name of	! .		rt, N.C.	
OL			1 Burial 2 CCremation 3 F 4 Donation 5 Other (Specify)		-	natory or other place	<sup>⊛)</sup> ¦ rp. ¦ 12-1∙		Towson	Maryland
Baltimore,	교원관승 .		21. Sign three Furniral Service (icens							Home, Inc.
ä	Depa Impo eny is		I Tout a tag	an		050 York			ryland 21	
ı			23a. Part1. Enter the disease, or composhock, or heart failure. List only of	cations that caused the recause on each line.	death. Do not ente	or the mode of dyin	g, such as cardiac o	or respiratory arrest		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cong	instur.	hemit	rai lu	u		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	nsequence of):	-0	11			70.7
	ţ	_	Sequentially list conditions,	Due to (or s a cor	rgrence of)	14	con			/ are
1	nsit	ulne.	Saquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Ø 0 ac		(4.4.5.04)	Car do	2000		2 4mg
o,	exection and ital-tra	Examiner	that initiated events resulting in death) Last	Due to ( as a cor	nsequence of):	V-W TOWN	DV I	244724		
68760,	uires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit	dical		d. =						
Ψ	ng ph	0	IF FEMALE:							
Вох	death certif e attending d for use a	lan/l	23b. Was decedent pregnant in the past 12 mophs?	3c. If yes, outcome of pr 1☐Live birth 2☐	Fetal death 3 -	Ectopic pregnancy			23d. Date of de Month	livery Day Year
	the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify)			NOTE:	1
P.0	that ti ed by detac		Part II. Other significant conditions con	ntributing to death but no	t resulting in the un	derlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Vital Records,	law requires that the as been signed by th 2 should be detache	d by						1 🗆 Yes	2 <b>0</b> 10 3 □ P	obably 4 Unknown
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Re	0 = 0	E O						autopsy performe 1 Yes 2	d? death?	completion of cause of 2□ No
ital	sician: Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of Death		NO TOTAL	
of V	Physic this ceral direct	2	examiner? 1 \( \text{Yes} \) 2 \( \text{No} \)	lospital: 1   Inpatient	2 ER/Outpatient	3□ DOA Oth	er: 4 Nursing Hor	me 5 Residenc	e 6 □Other (Spe	city)
n o	Attending Physician: r death. sctor: After this certific by the funeral director,		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injun Work		28d. Describe how	injury occurred	
sio	tend death for: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be	(l-)	A4 h		Yes 2 No	201 )		
Division	7 6 F C	Certification:	4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S)	pecify)	eet, factory, office		City or Town, S	et and Number or Ri State)	arai Houte Number,
_	To the Hospital or Attending F within 24 hours after death.  To the Funeral Director: After completely filled in by the funer.		29a. Certifier Certifying Phy	sician: To the best of my	/ knowledge, death	occurred at the tin	ne, date and place.	and due to the caus	se(s) and manner as	s stated.
	n 24 h	edical	(Check only 2 Medical Exami	ner: On the basis of exa- and manner stated.	mination and/or inv	estigation, in my o	pinion, death occurr	ed at the time, date	and place, and due	to the cause(s)
	To the To the Comp	ž	29b. Signature and tille of certifier		/	29c. License	e number	29d	Date signed (Mont	h, Day, Year)
			1 100	m f	hy so aan		2976	9	12/13	106
	5		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type, I	Print)	1. 1/1	10	0 11	my 2/228
	Sta	to.	31. Date filed (Month, Day, Year)	) A Laver	Signature	5 /6 4	1. leo/la	mild	Bull	and 700
	Sta Registr		DEC 1 4 201	06	K Ra	0				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death Physician uanita Mn SOM 4:106 Dec 3006 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner e 1more If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year 6. Sex 7. Age (In yrs. last\_birthday Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 □ F Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace American Indian. 11. Marital Status Black, White etc l □Yes 2□ fYes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☐ No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2/2/5 0/ 101 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place 1 ☑ Burial 2 ☐ Cremation 3 Removal from State Niemorial Kanda 115TOWN, 19 12-15-06 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Foreral Service Licensee FUNERAL HOME HOWELL 21207 LIBERTY HEIGHTS AVE, BALTIMORE, 4600 Enter the disease, or complications that caused the death-ck, or heart failure. List only one cause on each line. to not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Pa te vause (Final condition in death) **Physician** /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-trar Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: Other: 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 XNatural 2 ☐ Accident 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12 9006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201 St Paul Place Balt MD 31202

1

Registrar

State

31. Date filed (Month, Day, Year)

DEC 4

32. Registrar's Signature Part of the state of

	1	For State Amend item#1! Registrar  Decedent's Name (First, Middle,		2, 12/21/WCel	tificate of Dea	2. Date o		5 39738		
Physician	'	SAMUEL	Lasty	Month		Year				
/Medical Examiner	48	a. Facility Name (If not institution,		7)	4b. City, Town, or Locat	ion of Death	4c. County o	f Death		
	_	HARBOR HOSPIT		ige (In yrs. last birthday)	BALTIMOR If Under 1 Year   If Ur		of Birth	N/A  9. Birtholace (State or Foreign		
uneral irector	3.	212-48-1687	1 □ M 2 <b>X</b> □ F	58 Yrs.	Months Days Hou		of Birth n, <i>Day, Year)</i> n 1, 1948	Birthplace (State or Foreig Country)     Maryland		
*	$\vdash$	sual Residence of Decedent  0a. State 10b. County		10c. City, Town or Lo	eation			10d. Inside City Limi		
fied a		Maryland	N/A		Baltimo	ore		1 X Yes 2 □ N		
uner and be nutified Inner and be nutified Funeral Director	1	0e. Street and Number			10f. Zip Code	4005	10g. Citizen of W			
erai	-	-633 Caton Road 6	33 Cheraton R	t Ever in IIS 13	Was Decedent of Hispanic	1225 Origin? (Specify Yes of	or No- 14. Race	U.S.A American Indian,		
		1 X Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces	o? ₹No	If Yes, specify Cuban, Me: 1 ☐ Yes 2 🛣 No Spe	kican, Puerto Hican, etc	Specify:	, White, etc. Black		
dical		15. Decedent's (Specify only highest		(Give	dent's Usual Occupation kind of work done during	most of working	16b. Kind of Bus	Kind of Business/Industry		
or than "natural", c. t. the Mudical Exa. Completed by	-	Elementary/Secondary (0-12)	College (1-4o	r 5+) life.	DO NOT use retired)  Grounds K	eeper	Ba	ltimore City		
other than	1	7. Father's Name (First, Middle, L	ast)		18. M	lother's Name (First, Mi		)		
le marked o aumatic eve	L		Jones				Thelma Jones			
7 le m traum		19a. Informant's Name/Relationsh Thelma Jones	ip (Type, Print)		ng Address (Street and No 33 Caton Road Ba			itate, Zip Code)		
item 27 other tr	2	Oa. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place)	Date	20c. Location - C	City or Town, State		
ant: If its		1 Burial 2 SCremation 4 Donation 5 Other (Sp		0	o Crematory, No	12/15/0	6 Catons	sville, Maryland		
important: If any injury or once.	1	21. Signatur Funeral Service L	M. ES	22		acility ers Funeral Servi Place Baltimore,				
	T	23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caus	ed the death. Do not en line.				Approximate Interval Between Onset and Death		
ysician	11.4	Immediate Cause (Final disease or condition resulting in death)	_a_STAT	US EPILE	PTICUS			7 Hours		
ledical aminer	1	resulting in Gentli)		as a consequence of):	-INTESTINA	H RIFEN		7 Hours		
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burial-transit		in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		ITIC ENCE	PHALOPAT	HÀ		1 WEEK.		
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ate hes been signed by the ettending pl. page 2 should be detached for use as t Completed by Physician/Med	_	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)		23d. Date Mon	of delivery th Day Year		
should be deta		Part II. Dther significant condition	ns contributing to death	but not resulting in the c	ınderlying cause given in f	Part I. 23e.		bute to the cause of death?		
s beer 2 shou		EIRRHOSIS				24a.	Was an autopsy p	ere autopsy findings availa		
rector, page 2 in Be Complete		HEPATITIS C				10		eath? □Yes 2□NoX		
rector	3	25. Was case referred to medical examiner?	Hospital: 1XInpa		Other	Place of Death (Check		(0-4)		
S D		1  Yes 2  No  27. Manner of Death 1  Natural 5  Pending 2  Accident investig	28a. Date of I		ni 3 DOA 41		cribe how injury occurre			
within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral Medical Certification:		3 Suicide 6 Could r 4 Homicide determi	ned 289. Place of	Injury - At home, farm, st etc. (Specify)	reet, factory, office		tion (Street and Number or Town, State)	r or Rural Route Number,		
Third A hous all the total of the transfer of		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To the	29b. Signature and title of certifier 29c. License number 29d. Da							(Month, Day, Year)		
		▶ Mgwn2d	- WB		RESOC	טכ	DECEMB	er 08 2006		
1		30. Name and address of person  AMUSA NTATH				TH HANOVE	ER STREET	BALTIMORE		
9					1			, -		

DHMH 17 Rev 1/2001

ORIGINAL

	1	For State Registrar	State of Marylan		artment of H			giene () () (	39739
Dhysisian	_	I. Decedent's Name (First, Middle, La					2. Date of Dea Month	ath Day Yea	3. Time of Death
Physiciar /Medica		Marie	Jordon-Sap	Р				ber 8,20	
Examine		a. Facility Name (If not institution, given 1919 Maxwell			4b. City, Town, or Dunda	1k		4c. County of D Balti	
Funeral Director	2	215-46-8305	Sex 7. Age (In yrs. 1 1□M 2☐F 59	ast birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birt Min. (Month, Day NOV 7	y, <sub>Year)</sub> 9. 1 1947 Fr	Birthplace (State or Foreign Country) ance
p .	- 1	Usuat Residence of Decedent  10a. State 10b. County	10c Cib	. Town or Lo	ncation				10d. Inside City Limits
Maryla e-f ehov	_			und <i>a</i> l					1 ☐ Yes 2 ☐ No
3e or 28	1	10e. Street and Number 1919 Maxwell A	venue		10f. Zip Code 212	22		10g. Citizen of What USA	Country?
Baltimore, Maryland 21215-0036  permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28e-1 show any injury or other treumatic event. Ins Madical Examirer marks notified at		11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 🖾 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin an, Mexican, Pi Specify:	? (Specify Yes or No- uerto Rican, etc.)	Black, W	merican Indian, thite, etc. White
2 hou	ן ב	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busine	ss/Industry
Maryland 21215-0036 ad 2 should be filed within 72 hours at the and Mental Hygiene. 27 is marked other than "naturel", or treumatic event, the Medical Exam	Completed by	(Specify only highest ga	Coltege (1-4or 5+)	life.	kind of work done of DO NOT use retired	3)		Health	Department
d 21	5	17. Father's Name (First, Middle, Las	<i>t</i> ]	Admi	HISCIAC		Name (First, Middle,		Depar emerre
d be dental by ked of	ם ם	John F. Jordo					ricette		
aryla should I ind Meni ind Meni ind Meni ind Meni ind Meni		19a. Informant's Name/Relationship		19b. Maili	ng Address (Street			er, City or Town, Stat	e, Zip Code)
end 2 end 2 ealth a n 27 to		Dany Guadagna		1919	Maxwel	1 Ave	nue Dund		yland21222
or He	2	20a. Method of Disposition	¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬	emetery, cre	osition (Name of matory or other place	(e)	Date	20c. Location - City	
Pages Thent of I	1	1  Burial 2  □ Cremation 3 4  □ Donation 5  □ Other (Spec		ownsv	ville Ce	m 12,	/13/06	Crownsvi	lle, Md.
Baltimore, permit. Pages 1 et Depertment of Hea Important: if tem eny injury or othe		21. Signature of Funeral Service Lice		al Home,PA Md. 21222					
Object states		23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final	one cause on each line.	0 1			4		Approximate Interval Between Onset and Death
Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq		- melar	ona T	from les	reye	~ Sylam.
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	bDue to (or as a conseq	uence ot):					
76( ysicle	Ca	resulting in death) Last	Due to (or as a conseq	uence ot):					
, P.O. Box 68 that the death certifical ed by the attending ph detached for use as th		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna	Ideath 3	□Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
P.O. E	ysici	1 Yes 2 XNo	4 Pregnant at time of d 9 Unknown	eath 5(	Other (specify)				
I Records, P.O. Box 68 The law requires that the death certifica the has been signed by the attending phage 2 should be detached for use as the state of the stat	ed by P	Part II. Other significant conditions	contributing to death but not res	ulting in the t	underlying cause giv	ven in Part I.	23e. Did t	1	e to the cause of death?  Probably 4 Unknown
Vital Records, selen: The law requires to certificate has been signification, page 2 should be	Completed						24a. Was autop perfo	psy prior ormed? deat	
		25. Was case referred to medical examiner?				26. Ptace of	Death (Check only o		
of Vita Physician: rthis certific ral director.	0	1 ☐ Yes 2 ₹ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie		4 🗀 Nursii	ng Home 5 Resi	dence 6 □Other (	Specify)
After fune		27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigati		' 28b. Time o Injury	Wor	yat rk? Yes 2 ∐ No		how injury occurred	
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Hospi 14 hou Funer Tely fill	Medical	29a. Certifier (Check only one)  1 ☑ Certifying F 2 ☐ Medical Ex	Physician: To the best of my known aminer: On the basis of examination and manner stated.	wledge, dea ition and/or in	th occurred at the time time the time t	me, date and p opinion, death	place, and due to the occurred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
To the within 2 To the comple	ž	29b. Signature and title of certifier	0,		29c. Licens			29d. Date signed (M	
		Vaul (1	lary no		D	16587		December	11, 2006
10		30. Name and address of person who Faul Chang,	o completed cause of death (Iter	3 (e )		\$ 30	2, Towson	m MO 2	1204
Stat Registra	6	31. Date filed (Month, Day, Year)  DEC 1 4, 20	22. Registrar's Sign	iture					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sabina **Physician** Mary Johns December ΪΊ3, 2006 4:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Milford Manor Nursing Home Pikesville Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 213-03-0659 1 □ M 2 🕅 F Hours Director 07-03-1914 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show idical Examiner must be notified at Maryland Baltimore Gwynn Oak 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5413 Grandin Avenue 21207 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 X Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ulth and Mental Hygiene. 27 Is marked other than 'r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Cashier Movie Theater 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Mueller Frances Reh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rashida Uqdah - Friend 5413 Gradin Avenue Gwynn Oak, Maryland 21207 Department of Health a Important: If item 27 Is any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 12-18-2006 4 □ Donation 5 □ Other (Specify) Most Holy Redeemer Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc have Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the distribution and part in the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Mouro disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No 9 Unknown 3 ☐ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has I rector, page 2 s autopsy perform 2₽No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**□\_N**6 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No within 24 hours after death To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certification

31. Date filed (Month, Day, Yea,

DHMH 17 Rev 1/2001

29c, License number DV7569

1838 Green Tree Ad 21208

and manner stated

len

2006

MAD

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 12 12 2006 12:00 Frances Jiretza 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death <u>Parkville</u> Baltimore If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🔀 F 90 10/03/1916 maryland 10c. City, Town or Location 10d. Inside City Limits

1 ☐ Yes 2 No

3200 Cheseley Avenue 5. Social Security Number **Funeral** 216-09-1968 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State **Funeral Director** Baltimore <u>Parkville</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 3200 Cheseley Avenue 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Own\_Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Lasseth Mary Kapral ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald W. Cyryca, 431 Ridge Road Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/16/2006 | Baltimore, MD Gardens of Faith 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee Olegrandua & Bates 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ

23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director; After this certifica

**Physician** 

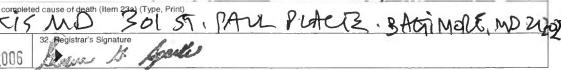
/Medical

**Examiner** 

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 7:10A M JANIE S. KIRK DEC. 11 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LIBERTY HEIGHTS NURSING BALTIMORE CITY REHABILITATION CENTER, Security Number 1 (8. Sec. Security Number 1 (8. Sec. Sec. 19. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 08/31/1914 **Funeral** Days 92 Yrs. 285-34-6546 N. CAROLINA Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Y es 2 □ No MD N/A BALTIMORE CITY Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21201 USA 1100 BOLTON ST., APT. 404 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes ¾☐ No Specify: Specify: BLACK þ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH 4 YEARS EDUCATOR/TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELIZABETH (LAST NAME UNKNOWN) ၉ JOHN SHIPMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SEVIER ST., GREENSBORO, NC 27406 GWENDOLYN BROWN / NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEM PARK 12/15/06 BALTIMORE CO. MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedit ause (Final disease or condition resulting in death) Oreast cancer 3 Yvs **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. En a certific Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hund theman. Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 831865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Entan street Balt md 821 nizr-Don 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 4 2006 Registrar

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		1- For State of Maryland / Department of Maryl	artment of Health and Mental Hy tificate of Death	rgiene 0 0 6	39743
Physic /Medi		1. Decedent's Name (First, Middle, Last)  Helen Koppelman	2. Date of Do Month Dec.	eath Day Year	3. Time of Death $1.0:4.5  A^{M}$
Exami Funeral		4a. Facility Name (If not institution, give street and number)  103 Center Place, Apt, # 217  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1	4b. City, Town, or Location of Death  Dundalk  If Under 1 Year   If Under 24 Hrs.   8. Date of Bi Months Days Hours Min.   7 – 30 – 1	4c. County of Death  Baltimo  th 9. Birth av, Year)	re place (State or Foreign
Director		216-01-6423			MD  10d. Inside City Limits
the Mary r 28a-f eh	Director	MD Baltimore Dunda  10e. Street and Number	.1k	10g. Citizen of What Cou	1 ☐ Yes 24☐ No
(1215-0036 within 72 hours after death with the Maryland ene. then "natural", or teeme 23a or 28a-f show than "natural Examiner must be notitled at	Funeral D	103 Center Place, Apt, # 217  11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 ☑ No	21222  Was Decedent of Hispanic Origin? (Specify Yes or Ni Yes, specify Cuban, Mexican, Puerto Rican, etc.)	USA 0- 14. Race - Ameri Black, White	
5-0036 72 hours aff natural', or	þ	3 ☐ Widowed 4 □ Divorced If Yes, Give Year or Dates:	Yes 2 No Specify:	Specify: Whi	
N pos	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	kind of work done during most of working OO NOT use retired)  memaker  18. Mother's Name (First, Middle	Own Home	2
a g g g e	To Be	Harry Croswell	Carrie Crosw	rell	p Code)
9 - 9 - 6 6 - 6 - 6		20a. Method of Disposition 20b. Place of Disposition cemetery, crem	O Haslemere Ct., Sil sition (Name of natory or other place) Crematory 12-14-06	20c. Location - City or T	own, State
Baltimor permit. Pages Department of Important: If it any njury or o		21. Signature of Funeral Scoop Licenses 22	Name and Address of Facility Bradley- A, 2134 Willow Sprin	Ashton Fung Road, 21	eral Home
Physician /Medical	Ÿ	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	arthe mode of dying, such as cardiac or respiratory a whom disease		Approximate Interval Between Onset and Death  JUGUS
8760, Care at the burial-transit and	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			Years
O. BOX 61 the death certific the ettending p ched for use as	Physician/Med		Ectopic pregnancy ] Other (specify)	23d. Date of delive Month	very Day Year
rds, P.O. I quires that the de in signed by the e uld be detached i	þ	Part II. Other significant conditions contributing to death but not resulting in the un		tobacco use contribute to Yes 2 No 3 ☐ Pro	the cause of death?
Vital Recordicien: The law requirectificate has been rector, page 2 should	Completed		1 ☐ Yes	ormed? death? 29 No 1 ☐ Yes	opsy findings available ompletion of cause of
ng Phys ter this	tion; To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Λ.	one) idence 6 Other (Specific how injury occurred	fy)
Division tall or Attendits after death.	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	set, factory, office 28f. Location City or To	(Street and Number or Rui own, State)	al Route Number,
Division  To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af	Medicai	29a. Certifier Check only only 2 Medical Examiner: On the basis of examination and/or invand and manner stated.	vestigation, in my opinion, death occurred at the time	, date and place, and due t	to the cause(s)
T wit		30. Name and address of person who completed cause of death (Item 23a) (Type, Theo done A. Stephens, 1005 N.	D-41399	12/13/0	6
4	ate	Theo dore A. Stephens, 1005 M.  31. Date filed (Month, Day, Year)  32. Signstra's Signature	in foint Blud, Ste 72	4, Iself Pi	21224
Regist		31. Date filed (Month, Day, Year)  DEC 1 4 2006  32. Signstrar's Signature			

06-09413	
Timothy Leggett	

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

imothy Leggett	1. For State Certificate of Death Registrer	Reg No. 2006 3974						
Physician/ Medical Examine	1 Decedent's Name (First, Middle, Last)	2. Date of Death Month Day December 10, 2006  3. Time of Death 1150 hrs						
iodiodi Examino	4a Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	h 4c. County of Death						
F	3746 Hickory Avenue Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	N/A s. [8. Date of Birth (MM/DD/YYYY)] 9 Birthplace (State or						
Funeral Director	258-25-0072   X M 2 F   37 Yrs.   Months   Days   Hours   Min.							
any	10a. State 10b County 10c. City, Town or Location	10d. Inside City Limits						
Maryland 28a-f show any d at once. ector	Maryland N/A Baltimore	1XX Yes 2 No						
ith the Maryland 23a or 28a-f she notified at once. al Director	10e. Street and Number 10f. Zip Code 21211	10g. Citizen of What Country?  USA						
or items must be	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 1 Yes 2 No 1 No Was Decedent Ever in U.S.  Armed Forces? 1 Yes 2 No 1 Yes, Specify Cuban, Mexican, Puerto 1 Yes, Give Year 1 Yes 2 No specify.							
utural" samine	1 or Dates: 1 Spendagle   Liquid Compation (City kind of )	work done 16b. Kind of Business/Industry						
ore, MD 21215-0036 ss I and 2 should be filed within 72 hours after of Health and Mental Hygiene If item 27 is marked other than "natural", ther traumatic event, the Medical Examiner To Be Completed by	Elementary/Secondary (0-12)  College (1-4 or 5+)  3+  Computer Graphics Specialist	DISH Network						
21215-0036 Juld be filed within 7 Mental Hygiene marked other than c event, the Medica	17. Father's Name (First, Middle, Last)  Donald L. Leggett  Cynth	e (First, Middle, Maiden Surname) hia Ward Carpenter						
D 212 should be and Ments 7 is mark natic even	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or F	Rural Route Number, City or Town, State, Zip Code)						
MD and 2 sho alth and im 27 is raumati	Melisa M. Leggett Wife 3746 Hickory Avenue  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Baltimore, Maryland 21211  Date   20c. Location - City or Town, State						
Baltimore, MD 2121 permit. Pages I and 2 should be fil Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event, TO Be	1 Burial 2 Cremation 3 Removal from State Metro Crematory 4 Donation 5 Other Specify:	/13/2006 Catonsville, MD						
Baltimo permit. Page Department o Important:	21. Size for e of Funeral Service Licensee  22. Name and Address of Facility  Burgee-Henss-Seitz  3631 Falls Road E  23a_Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	z Funeral Home, Inc.						
Physician	28a_Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	Baltimore, Maryland 21211 or respiratory arrest, shock, or heart Approximate Interval Between Onset and						
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Sharp Force Injuries to bilateral arms  Due to (or as a consequence of):	Death						
	Sequentially list conditions, b.							
Insit	if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated c							
: 68760, certificate be executed ending physician and use as the burial - transit	events resulting in death) Last  Due to (or as a consequence of).  d.							
760, Grate be executed g physician and the burial - transit ////////////////////////////////////	UNPENDED AMENDED							
3760, ificate be g physicis s the burn		23d Date of delivery lancy Month Day Year						
b. Box 687  the death certific  by the attending p  ched for use as the	past 12 months?  4 Pregnant at time of death 5 Other (Specify)							
that the derected for the condessed of the condessed for the conde		23e. Did tobacco use contribute to the cause of death?						
P.O. rires that the signed by libe detac		1 Yes 2 No 3 Probably 4 Unknown						
Records,  The law require ficate has been signage 2 should be		24a. Was an autopsy findings available prior to completion of cause of						
tal Reco sian: The law certificate has ector, page 2 s		performed?  1 V Yes 2 No 1 V Yes 2 No						
fital sician: is certification.	25. Was case referred to medical examiner?  Hospital: 1 Input 2 FR/Output 3 DOA Other Nursing	conly one) ing Home 5 Residence 6 ✔ Other Scene						
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sted in by the funeral director, page 2 should be refification: To Be Completed	1 Yes 2 No Thingatient 2 Elocadpatient 3 5 No Thingatient 2 Elocadpatient 3 5 No Thingatient 2 27. Manner of Death 28a Date of Injury 1 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending FOUND: 1 Yes 2 No	28d Describe how injury occurred Subject cut self						
Division ospital or Attending tours after death.  Ineral Director: After filled in by the fune Centification:	2 Accident   Investigation   Dec 10, 2006   1145 hrs   28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City						
Divis	Suicide 6 Could not be determined (Specify) Single Family	or Town, State) 3746 Hickory Avenue, Baltimore, MD						
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for use		at the time, date and place, and due to the cause(s)						
	29b. Signature and title of certifier  29c License number  O.C.M.E.	29d. Date signed (Month, Day, Year)  December 11, 2006						
Un	30. Name and address of person who completed cause of death (Item 23a)							
1	Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	01						
State 31. Date filed (Month, Day Year) Registrar  State 31. Date filed (Month, Day Year) Registrar  Registrar								

Dori

2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 6:58 PM 12 2006 Doris E. Lowner 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Good Samarita Beltimore
If Under 1 Year If Under 24 Hrs. Hospital Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🕱 F 212-12-2272 86 Director 11/03/1920 marvland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 7 is marked other then "naturel", or iteme 23a or 28a-f show treumatic event, the Madical Examinar must be notified at 1 ¥ Yes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 1650 Woodbourne Apt. 407 Avenue 21239 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No 1X Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: Specify: White 2 If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Loan clerk Banking 2 12 Pages 1 and 2 should be filed 18. Mother's Name (First, Middle, Maiden Sumame) land 17. Father's Name (First, Middle, Last) Be Carl Lowner 2 Elsie Kalk Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar importent: if item 27 is eny injury or other treu once. 1650 Woodbourne Ave. Apt. 409 Baltimore, MD 21239 Alva Blakemore, Friend Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/15/2006 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. Bates llobandna 5305 Harford Road. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of) Examiner As Diration Sequentially list conditions, if any, leading to immediate cause. Emer underlying Cause (Disease or injury that initiated events resulting in death) Last ren mo mia Due to (or as a consequence of): Examiner burial-transit certificate be executed Due to (or as a consequence of) the attending physician Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 2 No certificate 1 ☐ Yes 2 X No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Tyes 2 X No 1 🔀 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 KNatural 5 Pending 1 ☐ Yes 2 ☐ No lospitei or Attendii hours after death. unerei Director: A death. 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerei L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sanaritan Good Hospital 5601 Lock Raven Blod, Zhang Baltina 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			Registrar	d / Depa <i>Cei</i>	artment of Health and M tificate of Death		iene 0 0 6 •g. No.	39746					
3	Physici		1. Decedent's Name (First, Middle, Last)  Michael Elder Mason			2. Date of Deat	Day Year	3. Time of Death					
2	/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Dea						
76	Funeral Director		5. Social Security Number 234-66-8024 1 M 2 □ F 62	last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, July 9,	n/a year) 9. Bir 1944 Mar	thplace (State or Foreign ountry)					
- etc	D		Usual Residence of Decedent  10a. State 10b. County 10c. Cit	y, Town or Lo	cation		1544 1141	10d. Inside City Limits					
	Maryla Ing a	tor	·	sdowne	oation			1 ☐ Yes 2 ☑ No					
	or 28s	Direc	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What C	ountry?					
	death v	eral	57 Randall Ave  11. Marital Status 12. Was Decedent Ever in U.	S. 13. V	21227  Was Decedent of Hispanic Origin? (Spet Yes, specify Cuban, Mexican, Puerto		nited Stat						
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural, or Items 23a or 28s-f show event, I'm Medical Examiner must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☑ Married 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No 1 ☐ Yes, Give Year or Dates:		f Yes, specify Cuban, Mexican, Puèrto I ☐ Yes 2⊠ No Specify:	Rican, etc.)	Black, Whi						
15-(	in 72 h "natu redical	ojete	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give life, L	lent's Usual Occupation kind of work done during most of worki DO NOT use retired)	ing	16b. Kind of Business	Undustry City					
212	filed within Hygiene. other than	Comp	Elementary/Secondary (0-12) College (1-4or 5+)	1	k Driver			re government					
Maryland	should be filed withir or Mental Hygiene. marked other than imatic event, the M	Be	17. Father's Name (First, Middle, Last) Edwin Mason		18. Mother's Name	e (First, Middle, M e Glover	,						
aryl	2 should be f and Mental b le marked of eumatic eve	10	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Number or Rura			Zip Code)					
	1 and dealth em 27 ther tr		Linda Lee J. Mason / wife 20a. Method of Disposition 20b. P		andall Ave Lansdor		yland 2122 20c. Location - City or						
mor	0 0		1X Burial 2 ☐ Cremation 3 ☐ Bernoval from State	emetery, cren	rk Cemetery 12/10	11.							
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signalule of Fundal Service License	22	. Name and Address of Facility Amb	rose Fun	eral Home,	Inc.					
	20504		23a. Part 1. Enter the disease, or complications that caused the death		28 Sulphur Spring or the mode of dying, such as cardiac of			Approximate					
	Physician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   SEPSIS  Due to (or as a consequence of):										
68760,	Physician: The law requires that the death certificate be executed to this certificate has been signed by the attending physician and attail director, page 2 should be detached for use as the burial-transit of	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence	uence of):	CUBITAL ULCER			MONTHS					
P.O. Box 6	at the death certific by the attending pl tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of displayments.	death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year					
	res that igned b	þ	Part II. Other significant conditions contributing to death but not result.	-			acco use contribute to						
Records,	w requir been si should	eted			the theat Failure, reuse, Obesity	1 ☐ Ye	/-	robably 4 Unknown					
Vital Re	ian: The law rificate has stor. page 2 a	e Completed	Stage Four Decubital aller 25. Was case referred to medical	nj cu	26. Place of Death	autopsy perform 1 Yes 2	y prior to death? No 1 □ Yes	utopsy findings available completion of cause of					
of Vi	Physicia this cert al direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2		t 3 DOA Cther: 4 Nursing Hor			ocity)					
	D 0 0	ıtion:	27. Manner of Defith  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho	w injury occurred						
Division	F =	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hc building, etc. (Specific	ome, farm, stre	eet factory, office	28f. Location (Str. City or Town	reet and Number or R. , State)	ural Route Number,					
2)	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the time, date and place, a restigation, in my opinion, death occurred	and due to the ca ed at the time, da	use(s) and manner as	s stated.  to the cause(s)					
	To t To t	Σ	29b. Signature and the of partition		29c. License number		9d. Date signed (Mont						
	. 1		30. Name and address of person who completed cause of death (Item	Poctor 23a) (Type, 1	A\$2438528	`		11 2006					
	lu				on Ave. Baltim	we. m	0 21229						
	Sta Registi		DEC 1 4 2006	le d	A								
DH	MH 17 Rev 1/2	001	Julius J.	ORIGIN	IAI								

P.O. Box 68760, Records, Division or Vital After after death.

I Director: After the discount of the property of the fundamental of the fu

the Hospital or Attending within 24 hours after To the Funeral Dire

28a. Date of Injury 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

29b. Signature and title of certifier

D0063163

29d. Date signed (Month, Day, Year) December 13, 2006

M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Union Memorial Hospital, 201 East University Acknow Bultimore, Maryland 21218

State Registrar

Medical

DEC 1

UW ICHT Morrisch 06-09228 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2006 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day December 4, 2006 **Medical Examiner** MORRISEY, SR. 1553 hrs DWIGHT 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4303 Reisterstown Road N 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or **Funeral** Foreign Director Months Hours Country) Md 216-82-1924 1X M 2 41 9/28/1965 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Baltimore 28a-f show 1 X Yes 2 No N/Ahours after death with the Maryland rector s 23a or 28a-f notified at o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4303 Reisterstown Road 21215 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, or items 1 Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 2 Yes 2 X No 4 XDivorced If Yes, Give Year 1 Yes 2 X No specify: "natural", Specify:Black þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natinjury or other transmatic event, the Medical Exa Elementary/Secondary (0-12) College (1-4 or 5+) Construction Helper Construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Sylvester Morrisey Eugenia A. Morrisev ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Morrisey 7105 Rudisill Ct-2B, Baltimore, Md. 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Burial 2 X Cremation 3 crematory or other place) Removal from State Metro 12/13/06 Catonsville, Md. Crematory Other Specify. Donation 5 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service 1300 Eutaw Place Baltimore Md Issease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart A 23a. Part I. Ente Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical a Alcohol intoxication complicated by hypothermia Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) tending physician and use as the burial - transi executed Physician/Medical UNPENDED AMENDED #10c, perFH, G862, 12/14/06 TI Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760, 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Alcoholism Chronic 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available Mellitus Diubetes autopsy prior to completion of cause of has performed? death? this certificate ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? lospital: Inpatient 2 DOA ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene 1 V Yes After t 28d. Describe how injury occurred subject injested aliabel and 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: Natural 1 Yes 2 No in by the Director: fond 3:30pm Found 12-4-06 exposed to cold environment 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 4303 Reisferstown Rd Baltimore no Dwelling Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) hi O.C.M.E. December 5, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month) 32. Registrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene (1) (1)

Decedent's Name (First, Modie, Last)   Decedent's Same (First, Modie, Last)			For State Registrar	State	of Ma		partment of Fertificate of		nd Mental Hy	giene2 (	006	39749
Stammer  Sequence Sequence of Sequence (Sequence of Sequence of Se	Dhunia		1. Decedent's Name (First, Middle,	Last)					2. Date of De	ath	Vear	3. Time of Death
Solt Security Workship Service							METAI	,10				6:23 P <sup>M</sup>
2 De 18 13 27 Via. De 18 10 Court Via. Marin Burgar de Court Via. Marin Burgar de Court Via. Bala De Court V	Examir	ner	JOHNS HOPKINS	BAYVIEW	ME	CENTER	BAL	TIMO	RE			
To State   Doc County   Doc Cou			218-18-1437		-	V	Months Days		Min /Month Da	v Year)	9. Birthpl Coun Mary	lace (State or Foreign try) /Land
Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared March Specific Compared   Compared March Specific Compa	Maryland -f ehow	tor	10a. State 10b. County	. 1. 2		10c. City, Town or	Location		Edgeme	ore	11	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared   Compared March Specific Compared March Specific Compared   Compared March Specific Compa	with the or 28e		10e. Street and Number					21 21 0	Eagen	10g. Citizen		•
Be Beamentary/Secondary (0.12) College (1-4or 5+) Trom/Orker Local 16  6. Pearls Same First Marcis First Micros Number (1-10) Micros Name First Micros Number (1-10) Micros Nu	s after death , or items 23		11. Marital Status 1 ☐ Never Married 2 AMarrie	12. Was Dec Armed F ad 1  Yes If Yes, G	orces? 25 No ive	ver in U.S.	3. Was Decedent of H If Yes, specify Cub	lispanic Origi an, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	)- 14. F	tace - America Stack, White, o	an Indian, etc.
19. February Name (Pest, Mode, Mactor Summe)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Murper or Pater Route Number)   19. Medicing Address (Sincer and Number)   19. Medicing Address (Sincer and Number)   19. Medicing Address (Sincer and Number)   19. Medicing Address (Sincer and Number)   19. Medicing Address (Sincer and Number)   19. Medicing Address (Sincer and Number)   19. Medicing Address (Sincer and Number)   19. Medicing Address (Sincer and Number)   19. Medicing Address (Sincer and Number)   19. Medicing Address (Sincer and Number)   19. Medicing Address (Sincer and Number)   19. Medicing Address (Sincer and Number)   19. Medicing Address (Sincer and Number)   19. Medicing Address (Sincer and Number)   19. Medicing Address (Sincer and Number)   19. Medicing Address (Sincer and Number)   19. Medic	thin 72 hour. le. len "neturel" Madical Ex		15. Decedent' (Specify only highest	s Education grade completed	)	(Gi	cedent's Usual Occup ve kind of work done . DO NOT use retire	pation during most of d)	of working		WI	
Vincent Metallo   19a Informatis Name/Pasianoship (Type, Print)   19b Mailing Address (Sirver and Number or Paul Rouse Number City or Town, State, Zip Code)	T	a u		ast)		I	ronworker	18. Mother	's Name (First, Middle,			
22   Soroption of Debute (Speech)   23   Soroption of Street (Speech)   23   Soroption of Street (Speech)   23   Soroption of Street (Speech)   24   Soroption of Street (Speech)   25   Soroption of Street (Sp	should b nd Menta marked imatic e			ip (Type, Print)		19b. Ma	illing Address (Street	and Number				Code)
22   Soroption of Debute (Speech)   23   Soroption of Street (Speech)   23   Soroption of Street (Speech)   23   Soroption of Street (Speech)   24   Soroption of Street (Speech)   25   Soroption of Street (Sp	1 and 2 Heelth a em 27 ie ther treu			(Daugh	nter)	24	01 Oak Mar		ad Edgeme	re, Mai	ryland	21219
23. Part II. Ferre the disease, or complications that caused the death of not enter the mode of lying, such as cardad or respiratory arrest.    Approximate classes (Final disease or configuration)   Approximate classes (Final disea	Peges tment of I tent: If its		1 XBurial 2 Cremation 4 Donation 5 Other (So	ecify)	State	Cemetery, c	rematory or other pla n Cemeter	У	12/11/2006	Balt	imore,	Maryland
23. Part I. Firer the disease, or complexations that caused the death? Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate State   Cause (Final shock, or host fallative. Librory one cause on each line.)	Departing Department Important Income.		21. Sign fure of Ameral Service L	Try.	Yr.	L4191/1/						
Sequentially list conditions, and, leading to immediate cause. Either Underlying cause as a consequence of):    Due to (or as a consequence of):			Immediate Cause (Final disease or condition	a. HY	each line	CARBIL						Interval Between Onset and Death
Due to (or as a consequence of):    Consider of the construction o	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. A	SPI	RATION	PNE	UMON	IIA		13	4 DA45
The part of the pa	be executed sicien and burial-transit	Examin	that initiated events	0.	<u> </u>		TO TH	RIVE			1	MONTH
The property of the property o	ertificate ling phy e as the	Medic	IF FEMALE:	a	. = 5							
The part of the pa	the death c y the ettenc ached for us	nysician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live 4□Preg	birth 2 nant at ti	Fetal death		<i>'</i>				*
The property of the property o	equires that en signed b ould be det	þ	Part II. Other significant condition	ns contributing to	death but	not resulting in the	underlying cause giv	en in Part I.				
27. Manner of Death   1	2 50	Comple							autop perfo	osy rmed?	death?	
27. Manner of Death   1	slcian certif rector	00	examiner?	Hospital:	-11-7-30		- l Ott			100		
Kully Sublenties, MEDICAL DOCTOR RES - 000 DEC 7, Z006  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR KEWY SCHIENDORF 4440 EASTERN AVENUE BALTIMORE MD 21224  State 31. Date filed (Month, Day, Year)  32. Pegistrar's Signature	ng Phy Iter this	<b>—</b>	27. Manner of Death  1 Value 5 Pending	28a. Date (Mor	of Injury	28b. Time	of 28c. Injur	y at k?	28d. Describe I			)
Kully Sublenties, MEDICAL DOCTOR RES - 000 DEC 7, Z006  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR KEWY SCHIENDORF 4440 EASTERN AVENUE BALTIMORE MD 21224  State 31. Date filed (Month, Day, Year)  32. Pegistrar's Signature	et or Attens s after deat if Director; id in by the	Sertifica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Plac	e of Injunding, etc.	y - At home, farm, (Specify)		103 2	28f. Location (5	Street and Nur vn, State)	mber or Rural	Route Number,
Kelly Sublenties, MEDICAL DOCTOR RES -000 DEC 7, Z006  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR KELLY SCHLENDORF 4440 EASTERN AVENUE BALTIMORE MD 21224  State 31. Date filed (Month, Day, Year)  32. Pegistrar's Signature	Hospit     24 hour.     Funere     Hately fille		[Oriock Gray 2   Medical C	xaminer: On the t	Dasis of e	xamination and/or	ath occurred at the tid investigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time,	cause(s) and date and place	manner as sta e, and due to	ated. the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR KEWY SCHLENDORF 4440 EASTERN AVENUE BALTIMORE MD 21224  State 31. Date filled (Month, Day, Year) 32. Registrar's Signature	To th within To th compl	Me	29b. Signature and title of certifier  Kully Suhler	lus, M	EDIC	AL DOLTO						
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	10				se of dea							
The same of the sa			31. Date filed (Month, Day, Year) DEC 1 4		apgistrar	s Signature	74					•

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per doc 2863 1-3-07 Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2006 1:53am TRACY W. MEADOWS JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Future Care Old Court Randallstown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 1 M 2 □ F 8. Date of Birth
(Month, Day, Year
12-31-27 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 78 246-22-9144 Director N. Carolina Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show ob-al Examiner must be notified at Gwynn Oak Baltimore MD 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 USA 3300 Windsor Blvd by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 46 - 47 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status nit. Pages 1 and 2 should be filed within 72 hours after artment of Health and Mental Hygene. ortant: if Item 27 Is marked other than "natural", or Ite Inluy or other traumafte event, the Mer at Examine 1 Never Married 2 Married 1 ☐ Yes 2 No African-3altimore, Maryland 21215-0036 Specify 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Joseph J. Hock Elementary/Secondary (0-12) 10th College (1-4or 5+) Trucking Company Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tracy W. Meadows Sr. Margie Chory 19a. Informant's Name/Relationship (Type. Print)
Bettye Meadows/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3300 Windsor Blvd., Gwynn Oak, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Department o Important: If any Injury or once, Garrison Forest 12/11/06 Owings Mills, MD 22. Name and Address of Facility Wylie F/H P.A. of Balto. 21. Signature of Funeral Service Licenses 9200 Liberty Rd., Randallstown, MD 21133 23a Party Enter the disease of complice shock, or heart tenure list only on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner milune Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ailma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Inpatient 2 28h Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 00061436 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21215 MD NE BAZTIM ONE DSANY 2600 Har MD 小 31. Date filed (Month, Day, 32. Regetrar's Signature State

Registrar

DEC 1

4 2006

			1 - For State Registrar	State of Many		artment o		and Mental H	ygiene Reg. No.	006	39751
	# . V	je J	1. Decedent's Name (First, Middle, Last)					2. Date of D			3. Time of Death
	Physic /Medi		Edmund Francis	Murtha				Month Decemb	er 10.	Year 2006	5:30 P M
	Examir		4a. Facility Name (If not institution, give s	4b. City, Town	n, or Location o			4c. County of Death			
			410 Linwood Ave.			Bel A	ir		Har	ford	
	Funeral	0	5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Ye Months Da	ear If Under		irth	9. Birthp	place (State or Foreign
91	Director		098-07-4402	[M 2□ F 8	8 Yrs.	MOTILIS DA	lys Hours		0, 1918	R New	York
	pus		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	antion					
	sho sho	2		10	ic. Oity, Town of Lo	Cattori				'	0d. Inside City Limits 1√2 Yes 2 □ No
	the N	Director	Maryland Harford  10e. Street and Number		Bel Air	404 7: 0					
	with a o	Ö				10f. Zip Cod				of What Cour	ntry?
	leath	Funeral	410 Linwood Ave	Was Decedent Ever	rin II S 13 1	210		nin? (Specify Vec es N	USA	Race - Americ	an Indian
"	fter d	Ξ	1 Never Married 2X Married	Armed Forces?	13.1	f Yes, specify C	Suban, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	0- 14.	Black, White,	
930	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:		l□Yes 2√21	No Specify:		Spe	ecify:	ite
21215-0036	within 72 hours after death with the Maryland one. than "natural", or itema 23a or 28a-1 show he Mcdical Examinar must be notified at	Completed	15. Decedent's Educ	eation	16a. Deced	lent's Usual Oc	cupation		16b. Kind o	of Business/Inc	
218	thin 7	De l	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	life. L	kind of work do. DO NOT use rei	ne during most tired)	of working			,
	filed with Hygiene. Ither than	5		6	Resea	rch Pha	rmacolo	ogist	U.S.	Govern	ment
pu	be filed ital Hygi od other	Be (	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name (First, Middle			
yla	should be nd Mental marked o	2	John F. Murtha				Regir	na (nmn)	Sheeha	ın	
Maryland	2 sho and ls ma		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailin	g Address (Stre	eet and Numbe	r or Rural Route Numb	er, City or To	wn, State, Zip	Code)
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, the Modical Examiner must be notified at	V a	Cathryn D. Murtha		410	Lirwood	Ave.	Bel Air. N	Jarylan	d 2101	4
9	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 □Burial 2 □ Cremation 3 ☑Re		Ob. Place of Dispo cemetery, cren	sition (Name of natory or other p	place)	Date	20c. Location	on - City or To	wn, State
Baltimore,	Pant ner		4 □ Donation 5 □ Other (Specify)		Arlington	Nat'l	Cem. 1-	-22-07	Arling	ton. V	irginia
Sai	permit. Departr Imports any injt		21. Signature of Funeral Service License	•	1 22 M	Name and Add	dress of Facility Funeral	Home, P.A	١.		
	G () 2 6 0		HILLY I CUM	asterna		31/ Cok	esbury	Road, Abir	ngdon,	Maryla:	nd 21009
			23a. Part 1. Enter the disease, or complic shock, or heart dilure. List only on	ations that caused the cause or the cause on each line.	death. Do not ente	er the mode of o	dying, such as o	cardiac or respiratory a	arrest,		Approximate Interval Between
1:	Physician		Immediate Cause (Final disease or condition resulting in death)	5	E181	3					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co		200110	211				
1		-	Secuentially list conditions b	Due to (or as a co		51105	101				
1	led Isit	Examiner	Securationly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence or):	in love	01 P - 11	ORPHI	1 200	needo	
V	be executed sictan and burial-transit	xar	that initiated events c. resulting in death) Last	Due to (or as a co	nsequence of):	WHO	COLOF	SARRUM	1 HW	HOOM	
8760,	cate be executed bhysician and the burial-transit			D	EHUD!	PATIE	N				
687		edical	a.		Ungpi						-
Вох	eath certifii attending p for use as		IF FEMALE: 23b. Was decedent pregnant	ic. If yes, outcome of pr					234	Date of deliver	n/
ă	death a atte	cia	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ 4 Pregnant at time		Ectopic pregnar Other (specify)					Day Year
O.	at the de by the i	Physician/M	9 Unknown	9□ Unknown		,,,					
٦,	The law requires that the death certifited has been signed by the attending rage 2 should be detached for use as	by P	Part II. Other significant conditions cont	nbuting to death but no	t resulting in the un	derlying cause	given in Part I.	23e. Did	tobacco use c	ontribute to the	e cause of death?
Ď	quire an sig uld b	Pa						1	Yes 2□No	3 Proba	ably 4 Donknown
of Vital Records,	law requas been 2 shoul	Completed						24a. Was	an 24	b. Were auton	sy findings available
æ	The ta	Eo						auto perfo	psy prmed2	prior to com death?	pletion of cause of
Ta		0	25. Was case referred to medical				26 Place	of Death (Check only	20 No	1 🗆 Yes	2 No
>	Physician: this certific	OB	examiner?	spital:	2 ER/Outpatient	3□ DOA C	7thor	. /		Other (Specify)	1
0		L ii	27. Manner of Death	28a. Date of Injury (Month, Day Yea		28c. In		28d. Describe			/
<u>.</u>	Attending r death. ector: After by the fune	atic	1 Natural 5 Pending 2 Accident investigation	(Month), Day 1 or	ar) Injury		Yes 2 N	0			
Division	or Attan after deat Director: in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, stre	et, factory, offic	Ce C	28f. Location ( City or To	Street and Nu	mber or Rural	Route Number,
0	ital or A										
	To the Hospital or Attan within 24 hours after deati To the Funeral Director: completely filled in by the	edical		cian: To the best of my	knowledge, death	occurred at the	time, date and	place, and due to the	cause(s) and	manner as sta	ited.
	To the P within 24 To the F complete	Med		and manner stated.	2			. occurred at the time,			
	With Too	~	29b. Signature and title of certifier	() A	1. MO	29c. Lice	nse number	(191	29d. Date sig	ned (Month, D	Day, Year)
	241	-	, la	·	are 19	1		111	12	1121-	2006
	127		30. Name and address of person who com  Dr ANUSHA S1R17	repleted cause of death	(Item 23a) (Type, F	Print) CLAIR R	CAD C	USTEID C	Allen	CON. N	1021047
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's S	ignature	DENI P	ادرد	11010	, was	- 71	
42	Dociota Dociota	te	DEC 1 4 2006	See a Maria S	CASA	e-sa					

	1 - For State Registrar	State of Maryland		artment of H		nd Mental Hy	ygiene Reg. Ng. (	006	397	52
Physician	Decedent's Name (First, Middle, Last)     Richard (nmn) Na					2. Date of D Month		2006	3. Time of D	
/Medical Examiner	4a. Facility Name (If not institution, give Lorien Assisted Liv	street and number)  ving & Skilled			Air	Death	H,	unty of Death		
Funeral Director	5. Social Security Number 6. Sec. 15. 220-22-2952 Usual Residence of Decedent	7. Age (In yrs. Is	Yrs.	Months Days	If Under 24 Hours	Min. 8. Date of B (Month, D	ay, Year)		place (State or ntry) Land	Foreign
filed within 72 hours after death with the Maryland Hygiene. Hygiene. In Habitcal Evant at must be notified at MADOL NY COmpleted by Funeral Director.	10a. State 10b. County  Maryland Harford		, Town or Lo	cation				1	0d. Inside City	
with the Mar a or 28a-1 • be notified	10e. Street and Number			10f. Zip Code				of What Cour	ntry?	
riter death w	3404 Clairborne	12. Was Decedent Ever in U.S	5.   13. \	21009 Was Decedent of Hi	spanic Origin	? (Specify Yes or No Puerto Rican, etc.)	USA 14.	Race - Americ		
hours after tural; or ite	1 Never Married 2 Married 3 Widowed 4 Privorced	Armed Forces? 1♥Yes 2 □ No If Yes, Give Year or Dates:		f Yes, specify Cubai I□Yes 2√2 No	n, Mexican, F Specify:	ruerto Hican, etc.)		Black, White, e <i>cify:</i> Whi		
ed within 72 horygiene. Is the Medical 1. It we decided Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	lent's Usual Occupa kind of work done of DO NOT use retired,	luring most oi )	f working		of Business/In	-	
other the	8 17. Father's Name (First, Middle, Last)		Crane	Operator		Name (First, Middl			acture	r
0 = 0 = 1		lolny				hine Ida		,		
2 should and Men is marker raumatic	19a. Informant's Name/Relationship (Ty	rpe, Print)			and Number o	or Rural Route Num	ber, City or To	wn, State, Zip		
s 1 and F Health Itam 27 other tr	Lorraine Ash / Da 20a. Method of Disposition	20b. Pl	ace of Dispo	CLairbor sition (Name of natory or other place		Abingdo		21009 ion - City or To	own, State	
Pages ment of h	1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	lltop	Service C	orp. 1	2-13-06	Towso	n, Mar	yland	
permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny Injury or other traumatic average.	21. Signature of Funeral Service Licens	os Penut	$=\begin{bmatrix} \frac{22}{M}\\1 \end{bmatrix}$	Name and Address CCOMAS Fu 317 Cokes	s of Facility Ineral Bury F	Home, P.A	A.		7	009
	23a. Part 1. Enter the chease, or complishock, or heart the re. List only or	ications that caused the death ne cause on each line.	. Do not ent	er the mode of dying	g, such as ca	rdiac or respiratory	arrest,	-	Approximate Interval Betw Onset and De	reen
Physician / /Medical	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	HA G/	c stre	KES					
Examiner	Sequentially list conditions,	D								
executed in and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ianes of):							
be executed sicien and burial-transit	that initiated events resulting in death) Last	Due to (or as a consequ	ience of):							
ificate be er g physicien as the buria		d								
ettendin for use a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d	Date of delive	*	<del>e</del> ar
v requires that the de been signed by the should be detached	Part II. Other significant conditions con	•		, ,			tobacco use			eath?
The law requir	DIABETES			PERTEN		24a. Wa	san 2	4b. Were auto	psy findings a	vailable
Attending Physician: The law and adauth.  Sector: Alter this certificate has by the funeral director, page 2.						per	opsy formed? 2 10 No	death?	mpletion of ca 2□ No	use of
vita sician: certific rector,	25. Was case referred to medical examiner?	Hospital:	70.10	Othe		Death (Check only				
g Physical directions To	27. Manner of Death	1 Inpatient 2 I	ER/Outpatier 28b. Time of Injury	I 3L DOA	4 Nursi	ng Home 5 ☐ Res 28d. Describe	how injury or		y)	
t or Attending P after death. Director: After tin by the funera	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆 '	Yes 2□No					
tal or At rs after of al Direct ed in by	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location City or To	(Street and N own, State)	umber or Rura	i Route Numb	<i>⊕7</i> ,
Division of the Hospital or Attendia within 24 hours after death.  To the Funeral birector: A completely filled in by the funeral Medical Certification.	29a. Certifier (Check only one) 1 Cartifying Phy	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or in	occurred at the tim vestigation, in my op	ne, date and pointion, death	place, and due to the occurred at the time	e cause(s) and o, date and pla	d manner as s ice, and due to	lated. the cause(s)	
To the company of the	29b. Signature and title of certifier			29c. License	number		29d. Date si	gned (Month,	Day, Year)	
141	30. Name and address of person who co	ompleted cause of death (Item	23a) (Tyne	Print)	1534	4	12/1	10/20	06	
47'	SURESH DHAN.	7AVI, NO 6	225	UNIONA	WE H	AVRE DE	RACE	, MD :	U078	
State Registrar	31. Date filed (Month, Day, Year)	pmpleted cause of death (Item 7A V 1 71) 6	ture							
ricgistral	DEC 1 4 2006	Jacken 10	8 13							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2 0 6

					C	Sertificate of L	Death		Reg. No.	00 00100
	DI		1. Decedent's Name (First, Middle, Las	C 1				2. Date of De	eath Day	3. Time of Death
	Physicia /Medic		Katherine	Oberle				Month 12	03	06 10 IPM
1	Examin		4e Fecility Neme (If not institution, give	street and number)	209	2 hock lose	b. City, Town, or L		h 4c. County	of Death
			Alicemanorni			NAG	Baiti			
	Funeral		5. Social Security Number 6. Se	□ 14 057 E		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year)	Birthplace (State or Foreign Country)
	Director		184-22-0383	7	7 Yn	·		Mar 27	, 1929	
	and **	ŀ	Usual Residence of Decedent  10a. Stete 10b. County	10c.	City, Town o	r Location				10d. Inside City Limits
	with the Maryland a or 28a-1 show be notfled at	6	MD		Ra	ltimore				1. Yes 2 No
	138 Tab	Director	10e. Street end Number		Da	10f. Zip Code			10g. Citizen of V	Vhat Country?
	A S		2095 Rockrose Av	zenue		212	11			USA
	daath	Funeral	11. Maritel Status	12. Was Decedent Ever in	U,S.	13. Was Decedent of H	ispanic Origin? (So	ecify Yes or No	- 14. Rac	e - American Indian,
2	or He		1X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ◯ No	Ì	If Yes, specify Cuba		Hican, etc.)		k, White, etc.
2-0020	hours after death with the Maryland ural', or flems 23a or 28a-f show al Examiner must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify	
'n	2 E S	Completed	15. Decedent's Ed (Specify only highest gree		16a. D	ecedent's Usual Occupa Give kind of work done o	ation during most of work	unk aing	16b. Kind of Bu	usiness/Industry UNK
7	within then the Mex	후	Elementery/Secondary (0-12)	College (1-4or 5+)	·/i	fe. DO NOT use retired	0			
		ဒ္	G1110	ink		unk	18. Mother's Nam	n (Pinet 1 lielelle	Maidon Cumom	unk
and	be filed Ital Hyg od other event,	Be	17. Fether's Neme (First, Middle, Last)				18. Mother's Nam	e (FIISL, MICUIE	, Malueri Surriani	(4)
5	should ind Men imerke umetic	၉	40 44 44 45 46 46 46 46 46 46 46	0	405.1	lailing Address (Street	and Mambas as Dur	ml Doudo Mumb	or City or Town	State Zin Code)
Z Z	C/ @ = 8	- 1	19a. Informant's Name/Relationship (7	•		Service California			10 10 -11	1
	1 and Health Im 27 ther tr	-	Alice Manor Nursi 20a. Method of Disposition		Place of D	95 Rockrose isposition (Name of		Date		21211 City or Town, State
more,	Pages nent of int: If the iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐		cemetery,	crematory or other place	<i>(6)</i>			
	nit. Po artme prtant Injury	- 1	4 Donation 5 Other (Specify			22 Name and Address	ss of Facility			
n D	Depa Impo any I	- I	21. Signature of Funeral Service Licen- RONALO S	Wade, Directo	1	State Anato			Baltimo	ore Street
		$\dashv$	Jums	11111		Baltimore,			met	Approximate
			23a. Pert1. Enter the disease, of comp shock, or heart failure. List only of	one cause on each line.	saut. DO NO	enter the mode or dyin	g, such as calulac	or respiratory a	illest,	Interval Between Onset and Death
)	Physician /Medical		Immediate Ceuse (Final	A 1		No	ŧ.			
	Examiner		diseese or condition resulting in death)	0.	me		will			1
		<u>e</u>		0	,	nsequence of):				
	uted d ansit	Examiner	Sequentially list conditions	Ų. ————		nsequence of):				1
ລົ	exec en en riel-tr		Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury	21	1 2 5 16		mith o	QI. Tarla	- beh	VA / d / s
08/20	death certificate be executed e attending physicien end ed for use es the buriel-transit	edical	Ceuse (Disease or injury that initieted events resulting in deeth) Last	C. Due to	(or as e cor	sequence of):	noth o	10000	W.C	
0	<u>≡</u> 00 00	<u>8</u>	resulting in destry Last	. Por	woul	etino D	4 Pho of	7.		
o o o	w requires that the death cer been signed by the attendir should be datached for use	and		d			( 0/2-1	<u> </u>		
	e dea the at	by Physician/	Part II. Other significent conditions co	entributing to death but not i	esulting in t	ne underlying cause give	en in Part I.	23b. Did	tobacco use cor	ntribute to the cause of death?
5	d by t	£						10	Yes 2□ No	3 Probably 4 Unknown
Š,	requires that the reen signed by th hould be datache	<u>۾</u>						040 14/00		24b. Were autopsy findings
ecord	requ	Completed						perfe	an autopsy ormed?	available prior to completion of cause
	as as	ğ						25/1990		of death?
	cate h							10		1 Yes 2 No
VII	iclen: The cartificate iractor, peg	B	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deat			
5	This aldii	<u>د</u>	1 Yes 2 No  27. Menner of Death	1 L Inpatient 2	ER/Outp	atient 3LJ UOA	4 Mursing Ho		dence 6 Oth	
	After fune	盲	1 □Naturel 5 □ Pending	28a. Date of Injury (Month, Day Year)	Inju	iry Worl	k? Yes 2 □No			
DIVISION	deat deat ctor: y tha	fica	3 ☐ Suicide 6 ☐ Could not be		home, farm	, street, factory, office		28f. Location (	Street and Numb	er or Rural Route Number,
2	il or Attending F after death. I Director: After id in by tha funer	Certification:	4 ☐ Homicide determined	building, etc. (Spe	cify)			City or To	wn, State)	
	spita hours neral y fille	aic	29a. Certifier 1 Certifying Phy	ysician: To the best of my l	nowledge, d	leath occurred at the tin	ne, date and place,	and due to the	cause(s) and ma	nner as stated.
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this cartific completaly filled in by the funeral director.	edicai	(Check only 2 Medical Exam	iner: On the basis of exam and menner steted.	nation and/o	or investigation, in my of	pinion, death occur	red at the time,		
	Vithi Comp	Σ	29b. Signature end title of certifier			29c. Licens				d (Month, Day, Year)
			) / Lan	82	mi		31444		1216	6/06
		İ	30. Neme end eddress of person who o	completed cause of death (I	tem 23a) (Ty	rpe, Print)	D D T D.	, to 2h	8 201	71m 012 mp 2124
			SHOAIIS A. HAS	HMI MD	821	N, EKTA	N 71 70	1115 70	n mac	(117 0) LIZ (17 LIZ)
	Sta		31. Date filed (Month, Day, Year) DEC 1 4 2006	32. Registrar's Si	nature	de				
	Registr	al	DEC 1 4 7000	LACELLE JO	1	-				

DHMH 16 Rev 6/95

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			1 - For State Registrar	State of M	aryland /		artmen rtificate					ene.	06	3975	4
	Physici	an	1. Decedent's Name (First, Middle, Las	st)							2. Date of Death	Day	Vear	3. Time of Deat	th
	/Medic		Helen Teresa Pet								Novembe			7:10 AM	M
	Examir	ner	4a. Facility Name (If not institution, give 421 Deacon Brook						Location o				y of Death		
	Euporol		5. Social Security Number 6. S		e (In yrs. last b	oirthday)	If Under		stown If Under		8. Date of Birth		imore	place (State or Fore	eian
	Funeral Director			□M 210 F	77	Yrs.	Months	Days	Hours	Min	Sept 17,	1929	III:	inois	eigi i
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Jicsi Eracii et finast be i cdiffed at		10a. State 10b. County		10c. City, To	wn or Lo	cation						1	10d. Inside City Lim	nits
	e Mar	ctor	MD Baltimo	re	Re	eist	ersto	wn						1 □ Yes 21√2	No
	vith th	Funeral Director	10e. Street and Number				10f. Zip				10	g. Citizen of	What Cour	ntry?	
	s 238	erai	421 Deacon Brook		Suprim U.S.	140.5	Was Bassa	211					USA		
10	fter d	Fun	11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent Amed Forces? 1 ☐ Yes 2X1		13.	f Yes, spec	effy Cubar	n, Mexican	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ick, White,		
98	al', o	by	3  Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	₽ <b>X</b> No	Specify:			Specia	⁄∵ whi	te	
21215-0036	72 hc 'natur	Completed	15. Decedent's Ec		16	a. Deced	dent's Usua	l Occupa	ition	t of worki	ina 1	6b. Kind of E	Business/In	dustry	
121	within ene. than "	mpi	Elementary/Secondary (0-12)	Coltege (1-4or 5	5+)		kind of wor DO NOT us		)				1		
io B	filed v Hygie othar 1	ပ္ပ	17. Father's Name (First, Middle, Last)			no	usewi		18 Mothe	r'e Name	(First, Middle, M	own			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If itam 27 Is marked othar than "natural", or Itams 23a or 28a-f show or othar traumatic event, It a Medical Examiner must be notified at	To Be	Kostanty Nadziej								01eksial				
Nar	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (7) Ken Peters/son	Type, Print)							l Route Number, le Reist				
	1 and Health tam 27 other tr		20a. Method of Disposition		20b. Place				JOOK (			Dc. Location			
Baltimore,	Pages ment of ant: If it ury or c		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☒ Donation 5 ☐ Other (Specify		cemet	ery, cren	natory`or ot	her place	9)			55. 255411011	Ony or To	Wii, Glaio	
Balt	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		21. Signature Fineral Price Licen	Wade, Dire	ector	S t Ba	Name and ate A	address nato re,	s of Facility My Bo MD 2	y bard 2120	655 W. 1	3altim	ore S	treet	
			23a. Part1. Enter the disease, or compositely shock, or heart failure. List only	plications that caused one cause on each li	I the death. Do	not ent	er the mode	of dying	, such as	cardiac o	r respiratory arres	st,	1	Approximate Interval Between	
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	a. ENd	STA	RE	= H	SAR	71	FAIL	TURE			Onset and Death	
	/Medical Examiner		resulting in dealing	Due to (or as	a consequence	of:	0-		, 1	0				1.0-	
		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	of):	KER	iai	- 2	156	A56		- 1	410	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Ation	1 F	9/1	9/1/	to	DAL					1103	
o Ô	an an rial-tr		resulting in death) Last	Due to (or as	a consequence	of):			۸ -				-	1100	
8760,	cate be executed obysician and the burial-transit	dicai		d. CORDNA	MY.	HL	tell	1	013	EA	56			YRS	
9 xo	leath certifica attending ph I for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy							224 5			
ä	death a atten	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at	2 Fetal deat		Ectopic pre						ite of delive onth	ny Day Year	
о. О	that the de led by the a detached t	hys	9 Unknown	9□ Unknown											
Ś	90 90	by	Part II. Other significent conditions of	ontributing to death be	ut not resulting	in the un	aderlying ca	use give	n in Part I.					e cause of death?	
Record	s been s	olete	lEFT Bludle	ROWEL	RINCE	1	4010	4			24a. Was an	24b.	Were autor	osy findings availat	ble
		Completed	Myocardial	INFAR	CHON	1	7000				autopsy performe 1 \( \text{Yes} \) 2	gl?	prior to con death? 1 □ Yes	npletion of cause o	of
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	771831						Check on one				
0	Phys or this oral di	To To	1 ☐ Yes 2 No 27. Manner of Death	1 ∐ Inpatie 28a. Date of Injui (Month, Day	nt 2 ER/O y 28b.	utpatient Time of		C. Injury	' 4 □ Nur at		ne 5 K Residen 28d. Describe how			)	
lo	Attending Physician: r death. actor: After this certific by the funeral director,	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		(Year)	Injury	М	lc. Injury Work? 1 🗆 Y	? es 2 □ N			,,			
Division	in Sir de	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubuilding, etc	ry - At home, f c. (Specify)	arm, stre	et, factory,	office		2	28f. Location (Stre City or Town,	et and Numb State)	er or Rurai	Route Number,	
	To the Hospital or A within 24 hours after To the Funaral Dire completely filled in b.	edicai C	29a. Certifier 1 Certifying Phy (Check only one)	ysicien: To the best of hiner: On the basis of and manner sta	examination at	je, death nd/or inv	occurred a estigation,	t the time in my opi	e, date and nion, deat	i place, a	and due to the cau ed at the time, date	se(s) and ma e and place,	anner as sta and due to	ated. the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	1.11		. 1		License				. Date signe		-	
			· Willin !	Keill	y m		0	54	74	9		1/21	12	006	
			30. Name and address of person who o	completed cause of	h (Item 23a)	(Type, f	Print)		3		. 0	4.3		006 1d 2122	
			31. Date filed (Month, Day, Year)	MO 9	CHS7 ur's Signature	K	OlliN	gC	ROS	sROC	205, 104	Himor	re, M	10 2/22	8
	Sta Registra		DEC 1 4 200	67	N. A	Joen	20								

			1 - State of Maryland / Registrer		artment of rtificate of				iene200	6 39755			
	Physici	~	1. Decedent's Name (First, Middle, Last)  Eva Marian Patterson				1_	Date of Death Month ECEINDEY		3. Time of Death 7:50P M			
	/Medio Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town,			CCCIIIDCI	4c. County of I	Death			
			Pear Tree  5. Social Security Number 6. Sex 7. Age (In yrs. last b.	irthdav)	Pas If Under 1 Year	adena r If Under	24 Hrs. 8	. Date of Birth		Arundel			
	Funeral Director		173-26-9450 1□M 2⊠F 94	Yrs.	Months Days		Min.	Date of Birth (Month, Pay, OV 14	1912	Birthplace (State or Foreign Country)			
	yland		Usual Residence of Decedent           10a. State         10b. County         10c. City, Tow	en or Lo	ocation					10d. Inside City Limits			
	Ba-fs	ector	Maryland Anne Arundel		1	adena				1 □ Yes 2 □ No			
	3a or 2	N DIC	10e. Street and Number 230 Inlet Drive		10f. Zip Code	211	22	10	og. Citizen of Wha	ISA			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In Important: If item 27 is marked other than "natural", or items 23a or 28a-f show mit propriet of the Traumatic event, I'm Medical Examination in the Inditional any night of the Inditional Examination of the Inditional Examination of the Inditional Examination of the Inditional Examination of the Inditional Examination of the Inditional Examination of the Inditional Examination of the Inditional Examination of the Inditional Examination of the Inditional Examination of the Inditional Inditional Inditional Inditional Inditional Inditional Indiana Indian	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu			fy Yes or No- can, etc.)		American Indian, White, etc. White			
Baltimore, Maryland 21215-0036	a within 72 ho liene. r than "natur ine Medicel	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  15. Decedent's Education (Specify only highest grade completed)  College (1-4or 5+) 4	(Give	dent's Usual Occu kind of work done DO NOT use retin HOMEM	e during mos ed)	t of working	1	16b. Kind of Business/Industry Household				
yland 2	Duid be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Edward Shaffer			Mary	,	Jane	<sup>faiden Sumame)</sup> Fisher				
Mar	nd 2 shoulth and 27 is m		19a Informant's Name/Relationship (Type, Print) Barbara Williams (daughter)	D. Mailin 230	ng Address (Stree Inlet D	rive,	Pasad	Route Number, ena MD	City or Town, Sta 21122	te, Zip Code)			
Jore,	Pages 1 ar		1 Burial 2 Cremation 3 Removal from State	ery, cren	sition (Name of matory or other pla 11 Cemet	ace) D	ec. 1 2006	<sup>e</sup> 3	loc. Location - Cit	y or Town, State e, Maryland			
Saltin	emait. Pa epertmer nportant ny njury 006.		4 Donation 5 Other (Specify)  21. Signature of Euneral Service Inc. nsee	_	2. Name and Addr	oss or racing	' 5	talling	ıs Funera	ll Home, P.A.			
	0 □ E € Ø		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart ailure. List only one cause on each line.	not ent	3111 MO er the mode of dy	untain ing, such as	Road cardiac or r	, Pasad	lena, MD st.	Approximate			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	40,	pathy	4-	-/-			Interval Between Onset and Death			
E	Examiner		Porishpo	fil	New	srop.	4 Hhr	1		5 years			
	and Il-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	of):			/			/			
68760	icate be executed physician and s the burial-transit	dlcal											
O. Box (	at the death certificate be executed by the attending physician and tached for use as the burral-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 ments? 1 □ Yes 2 ™ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnand Other (specify)	су			23d. Date of Month	delivery Day Year			
rds, P	The law requires that the te has been signed by thi sage 2 should be detache	Ď	Part II. Other significant conditions contributing to death but not resulting	in the ur	nderlying cause g	iven in Part I.		23e. Did toba	and the second	te to the cause of death?  Probably 4 Unknown			
_	Ø 14	Completed						24a. Whas an autopsy perform 1 ☐ Yes 2	prior				
	ysician: T is certificat director, pa	To Be	25. Was case referred to medical examiner?  1   Yes   2   146   Hospital: 1   Inpatient   2   ER/O	utpatien	at 3□ DOA O	u		Check only one	nce 6 Dether (	Specify / Willy			
on of	Attending Physician: r death. ector: After this certific by the funeral director.		27. Manner Death 1 Pratural 5 Pending 28a. Date of Injury (Month, Day Year) 28b.	Time of Injury	28c. Inju		28		w injury occurred				
Division	al or Attendated after death	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	arm, stre				Location (Str. City or Town,		r Rural Route Number,			
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination at and manner stated.	e, death	n occurred at the t vestigation, in my	time, date an opinion, dea	d place, and th occurred	d due to the car at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)			
	To the To the compl	Me	29b. Signature and title of certifier		29c. Licen	nse number	94	29	d. Date signed (N	fonth, Day, Year)			
	10		30. Name and address of person who confipleted cause of death (Hern 23a)	(Туре,	Print) 1	200	1/	0	12/1/	D . A			
	<b>Q</b> Sta	te.	Ellott Horbaty und 1911 31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	144150	10	ark.	vsive	1 Her.	DV/11/149, 2106			
	Registr		DEC 1 / 2006 6 4	1.	. 60 0				,				

				State of M	iarylar	nd / Depa	artment of H	Health and M	lental Hy	gien	e) 11 11	15	39756
				1 State Registrar		Ce	rtificate of	Death		Reg. N		U	33730
		Dhamini		Decedent's Name (First, Middle, Last)					2. Date of De Month	eath Da	214	Yeer	3. Time of Death
		Physici /Medi		Francis Joseph Prevost S	r.				Doce	4 (a.e.		200	642AM
	)	Examir		4a. Facility Name (If not institution, give street and number			4b. City, Town, o	or Location of Death		40	c. County of	Death	<b>3</b> .
	1			Upper Chesapeake Medical	Cent	er	Bel Air				Harfo	rd	
		Funeral	П	5. Social Security Number 6. Sex 7. A		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi (Month, D	rth	lario	9. Birthol	lace (State or Foreign
		Director		458-74 <b>-</b> 3383 <sup>1⊠M 2□F</sup>	63	Yrs.	Months Days	Hours Min.	July 1	.6 .	1943	Coun. Dueb	ec, Canada
		D		Usual Residence of Decedent									
		how	١.	10a. State 10b. County	10c. Cit	ty, Town or Lo	ecation					10	0d. Inside City Limits
		n the Marylan r 28e-f ehow	Ş	Maryland Harford	Edc	rewood							1 ☐ Yes 2 XNo
		death with the Maryland ms 23a or 28a-f show (must be notified at	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of Wh	nat Coun	try?
		h wit		3472 Albantowne Way			21040			USZ	Λ.		
		deat	Funerai	11. Marital Status 12. Was Deceden	Ever in U		Was Decedent of H	hispanic Origin? (Sp	ecify Yes or No		14. Race -		
_	ဟ	after or Ita	Ē	Armed Forces  1 □ Never Married 27 Married 17 Yes, Give				an, Mexican, Puerto	Rican, etc.)		Black,	White, e	etc.
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0	<u>a</u>	kad be	To B	Joseph Hildege Prevost				Laurent	Grace	Wat	tie		
L	3	12 should be filed within h and Mental Hygiene. 7 is markad othar than " traumatic event, the Mar	_	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street	and Number or Rura				ate, Zip	Code)
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0	5	- 7 5 5		20a. Method of Disposition	20b. F	lace of Dispo	sition (Name of	Road, Jor	Date TIL	20c. L	ocation - Ci	ity or To	wn, State
10/10	Baltimore, Maryland	age ent o nt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	•	-	natory or other plac	1		_		225.000	
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5	Ĕ	ding Phys h. After this funeral dir	on:	27. Manner of Death  1 Natural 5 Pending  28a. Date of Inju (Month, De	iry iy Year)	28b. Time of Injury	28c. Injun Worl		28d. Describe	how inju	ry occurred		
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erost	Division	or At fter c	Certification:	4 Homicide determined 28e. Place of In building, e	ury - At ho c. <i>(Specif</i> )	ome, farm, stre	eet, factory, office		28f. Location ( City or To	Street ar vn, State	nd Number e)	or Rurai	Route Number,
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		To the Hospital or Attandi within 24 hours after death. To the Funsral Director: A completely filled in by the fu	Mec	29b. Signature and title of certifier	2100.		29c. License				te signed (/		
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06-09475 Steven Richey

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Date of Death Time of Death Physician/ Month Day December 12, 2006 1130 hrs Medical Examiner A WARD City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** Months Days 08 Director 80 I0c. City, Town or Location 10d Inside City Limits V Yes 2 Director 10g Citizen of What Country? 10e Street and Numbe Funeral 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14 Race - American Indian, Black Examiner must be Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married Yes Yes 2 No specify: Widowed Divorced If Yes. Give Year <u>چ</u> 16a Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+ If item 27 is marked other than ' 12 should be filed within th and Mental Hygiene 17. Father's Name (First, Middle, Last) 's Name (First, Middle, Maiden Sur HOWARD Be or other traumatic event. 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code) ဥ 20b. Place of Disposition (Name of cemetery crematory or other place) Cremation 3 06 Important: Donation 5 Other Specify BALLOM Part. Enter the disease, or complications that caused the death. Do not enter such as cardiac or respiratory arrest, shock, or hear Approximate Interva **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a Gunshot Wound of Torso Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial #28d, perME, g862, 12/14/06 TT Box 68760, 23d Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ Yes 2 No 3 Probably 4 Unknown مَ Completed 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed? 1 🗸 Yes ✓ Yes 2 25. Was case referred to medical 26 Place of Death (Check only one) Be Other<sub>4</sub> examiner? Nursing Home 5 Residence 6 1 / Inpatient 2 ER/Outpatient 3 After this 2 2 ✓ Yes 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification Dec 12, 2006 0920 hrs Yes 2 🗸 No 5 Pending within 24 hours after death To the Funeral Director: subject shot the Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 3446 Cliftmont Avenue, Baltimore, MD determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E December 13, 2006 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, 32. Resistrar's Signature Day Year)

State Registrar

Registrar DHMH 17 Rev 1/2001 **DEC 14** 

			For 1 _ State	State of Maryland / Department of Health and Mental Hygiene 116 397	59
			Registrar	Certificate of Death Reg. No.	
	Physici	an	Decedent's Name (First, Middle, La	Month Day Year	eath
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	ehov	2	10a. State 10b. County	10c. City, Town or Location	
	the N	Director	10e. Street and Number	ester East New Market  101. Zip Code  100. Citizen of What Country?	
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	death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian,	
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Maryland	s 1 and 2 should f Health and Mer Item 27 is marks other traumatic		19a. Informant's Name/Relationship (	Type, P nt)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
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Baltimore	그 된 원 글 .		21. Signature of Funeral Service Licen	Complete	
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			23a. Part1. Inter the disease, or com shock or heart failure. List only		
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	/Medical Examiner		resulting in dealin)	Due to (or as a consequence of):	
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_		603 1	IF FEMALE:	23c. If yes, outcome of pregnancy	
Вох	feath certif attending I for use a	clan	23b. Was decedent pregnant in the past 12 months?	1   Live birth 2   Fetal death 3   Ectopic pregnancy   23d. Date of delivery   4   Pregnant at time of death 5   Other (specify)   Month Day Yea	ır
P.O.	t the c by the achec	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	
	The law requires thet the death certife thas been signed by the attending page 2 should be detached for use a	by P	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death	th?
ord	w require	ted		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∰Unk	nown.
ec	e law n has be	Completed		24a. Was an autopsy findings ava prior to completion of caus	ulable
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Ę	sicier	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)  Hospital:   Inpatient 2 FR/Outpatient 3 DOA Other A Nursing Home 5 FR Patients C FROM C 1	,,
o	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	sie_
ion	utending F death. ctor: After the funera	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		
Division of Vital Records,	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number City or Town, State)	;
Ω	pital c urs ef eral D		00-0-17		
	To the Hospital or Attending Physicien: The within 24 hours effer death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  riner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	withir To th comp	ž	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)	
)			100	Bridges MD P15723 12-14-06	
	1		D = D	completed cause of death (Item 23a) (Type, Print)	
	Sta	to	31. Date filed (Month, Day, Year)	10 North Greene Street, Daltmore, Mayland 21201	
	Registra			32. Jegistrar's Signature	

06-09450	
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06-09450 Rafal Paul Szczep		Please Type or Print in Black Indelible Ink.  State of Maryland / Department of He  Certificate of De	ealth and Menta			e. 2006 3976
Physician	1/	Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of		3 Time of Death
Medical Examine			ty, Town, or Location of			2006 1430 hrs County of Death Anne Arundel
Funeral Director	ļ		Under 1 Year If Under 2 ponths Days Hours	B. Circ	of Birth (MM/	DD/YYYY) 9. Birthplace (State or Foreign Country) Poland
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiene XI is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Md.   10b. County   10c. City, Town or Location   Hanover	Zip Code		I 10a Citi	10d Inside City Limits 1 Yes 2 No
th the Ma 23a or 28 notified a	e	7502 Knoll Acres Road	21076			USA
ifter death wii	Fune	1 X Never Married 2 Married Armed Forces? If Yes, sp	edent of Hispanic Origin becify Cuban, Mexican, P		)	14. Race - American Indian, Black, White, etc  Specify: White
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MD 21 and 2 should alth and Mer m 27 is man aumatic ev	0	Mrs. Hanna Szczepanowska/ Mother 903 W.	University	/ Parkway	/ Balt	ity or Town, State, Zip Code)
Baltimore, permit Pages I an Department of Hee Important: If ite		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify.  20b. Place of Disposition crematory or other pl  Dulaney Val.	Ley Cem.	Date 12/16/06	Ti	Location - City or Town, State
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Box (the death ce by the attence thed for use	잗.	1 Yes 2 No 9 Unknown  4 Pregnant at time of death 5 Other (9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underl		230 D	id tobacco	use contribute to the cause of death?
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Single Family	tory, office building, etc.	or Tow	n. State)	nd Number or Rural Route Number, City pad, Hanover, MD
To the Hos within 24 h completely	edical	29a Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred a one) Medical Examiner: On the basis of examination and/or investigation, in and manner stated	n my opinion, death occur		ate and pla	ce, and due to the cause(s)
		29b. Signature and title of dertifier	O.C.M.E.			Date signed (Month, Day, Year) ember 12, 2006
5		30. Name and address of person who completed cause of death (Item 23a)  Susan Hogan MD. Assistant Medical Examiner 111 Penn St	reet, Baltimore, MI	21201		
Stat	te	31. Date filed (Month, Day Year) 4 2006 32. Registrar's Signature	20			

State of Maryland / Department of Health and Mental Hygiene 000

Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Dec 5, 2006 11:49 a Delia A. Stover /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A **Baltimore** St. Agnes Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 12, 1913 9. Birthplace (State or Foreign **Funeral** Months 1 M X2 F Days Hours No. Carolina 93 Director 244-34-1617 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location r than "natural", or Items 23s or 28s-1 show the Medical Examiner must be notified at 10d. Inside City Limits **Baltimore** N/A 1 Yes 2 □ No Marviand Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21229 13 South Hilton Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2000 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 255No Specify: Black þ Specify: ₩SWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Pages 1 and 2 should be filed inent of Health and Mental Hygident: If item 27 is marked other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Candis Morrison John Morrison 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trai 13 South Hilton Street Baltimore, Maryland 21229 Shirley A. Stover Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Windsor Mill, Md. 12/12/06 4 Donation 5 Other (Specify) King Memorial Park 21. Signature Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 1. Enter the dist ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** C. Diff Colitis weeks /Medical Due to (or as a consequence of): Examiner Septic Shock 4 days Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ö in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 70 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Director: After 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) Tyothi funnam, P19925 MD DEC, 05,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PUNNAM 900 S. CATON AVENUE, BALTIMORE, MD 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 1 4 2006 Registrar

06-09428 Giuliano Santos		Please Type or Print in Black Indelible Ink. Ensure All Cop		jible.	
Giuliano Santos		State of Maryland / Department of Health and Mental Certificate of Death		2008	39762
Physicia Medical Exami	in/	Registrar  1 Decedent's Name (First, Middle Last) Giuliano Michael Santos	2. Date of Death Month December	h T	3 Time of Death 2159 hrs
		4a. Facility Name (if not institution, give street and number)  Johns Hopkins Hospital  4b. City, Town, or Location of De Baltimore		4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs. 8. Date of Birt	h (MM/DD/YYYY) 9 Birth	
Director		213-23-5769 1X M 2 F 17 Yrs. Months Days Hours	12-16	5-1988 Foreign	ntry) MD
>,		Usual Residence of Decedent  10a. State 10b. County 10c. City. Town or Location			40.11
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ryland ra-f sh	ę	MD Baltimore City  10e Street and Number 10f Zip Code	110	g. Citizen of What Coun	Λ
the Ma a or 28	Director	1421 Broening Highway 21224		USA	,
r with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? 15. Nover Married 2 Married Armed Forces? 15. Nover Married 2 Married Armed Forces?		14. Race - Americ White, etc.	an Indian, Black,
r death or ite	Fun	1 Yes 2 X No		Specify Whi	+ 0
irs afte	à	3 Widowed 4 Divorced If Yes, Give Year or Doubles:  1 X Yes 2 No specify S 1  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind		16b. Kind of Business/In	
72 hou n "nat	etec	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use	retired)		,
0036 within iene er tha	Completed	10 Student		Studen	t
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212 uld be Menta mark c even	o Be	David Neil Santos, Sr. Pamel:  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number	a Cain or Rural Route Num	ber, City or Town, State,	Zip Code)
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		Pamela Santos - Mother 1421 Broening His		altimore,	MD 21224
ore, es Lan of Hea If iter		20a Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or T	
timent rtant:		4 Donation 5 Other Specify		Baltimor	
Bal permii Depar Inipo		21. Signature of Furneral Service Licensee  22. Name and Address of Facility B1  PA 2134 Will 10			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line.	ac or respiratory arre	est, shock, or heart	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease a. Multiple Gunshot Wounds			Between Onset and Death
		or condition resulting in death)  Due to (or as a consequence of):			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	· · · · ·		
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executed an and al-transit	al E	d			
al al	Physician/Medical Examiner	UNPENDED AMENDED			
3876 rtificat ing ph	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre	egnancy	23d Date of delivery  Month Da	ay Year
Box 68760 e death certificate h the attending physical ed for use as the bu	/sici	4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
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1 of Vi ling Physi After this funeral dir	٦.	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred	
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Divis Hospital or A 24 hours after Funeral Dire		4 V Homicide determined (Specify) Local Street		ood Avenue, Baltimor	
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F 3 F 5	ž	29b. Signature and title of certifier 29c. License number		29d Date signed (Mont	,
		O.C.M.E.		December 11, 200	Jb
~ ~		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201		
St Regist	ate rar	31. Date filed (Month, Day, Year) DEC 1 4 2006  32. Registrar's Signature		<del></del> -	
DHMH 17 Rev 1/2		OPICINAL			

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	tand		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				100	d. Inside City Limits
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Mai	C1 00 - 4		19a. Informant's Name/Relationship ( Lois J. Shiff1	* * *	1		Street and Number or Rui				
, e	Health tem 27		20a. Method of Disposition	err- wire		Disposition (Name crematory or other	mine Road	Date		n - City or Town	
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Saltimo	교육관중 .		21. Signature of Funeral Service Lice	**		22. Name and	Address of Facility Br	adlev-	Ashton	Funo	ral Home
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	/Medical Examiner		resulting in death)	Due to (or as	a odnsequence of	):					
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	he Ho in 24 he Fu pletel	Medical	(Check only 2 Medical Examone)	miner: On the basis of and manner sta	examination and/	or investigation, in	my opinion, death occur	red at the time,	date and place	and due to th	e cause(s)
	To I To I	Σ	29b. Signature and title of certifier	/		29c. l	icense number		29d. Date sign	ned (Month, Da	y, Year)
			r newy Ke	acu o	70	0	16125		12/1	0106	>
	5		30. Name and address of person who	EDON F	eath (Item 23a) (T	ype, Print)	charles	ch. i	2 16	01	21204
10	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	10170.	Crialles	24 - 7	50110	· 'a.	-1204
	Registr		70014	2000	20	1.00					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item I per doc g862 12-14-06 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. UUS 1. Decedent's Name (First, Middle, Last) SINGER Yono Lena 2. Date of Death 3. Time of Death Singer **Physician** Day DECEMBER 11:00 A 2006 /Medical 11 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CENTER. RANDALLSTOWN HOSCITAL NORTHWEST If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 03/26/1903 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 20 F 220-46-9202 103 Director MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location or 28a-f ehow 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8105 ANITA ROAD 21208 Itema 23a USA e filed within 72 hours after death in Hygiene. other than "natural", or Itema 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify ₹ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PROPRIETOR ARMY/NAVY STORE permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked oth any injury or other traumatic event 9058. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BENJAMIN **MILLER** BESSIE **MILLER** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8105 ANITA ROAD - BALTIMORE, MD 21208 CARL SINGER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON CHIZUK AMUNO 12/13/2006 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner PINERMONIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a guntequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death Dav Year signed by the a 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 1 No funeral director. Be 25. Was case referred to medical 26. Place of Death Check only one examiner' 1 ☐ Yes 2 No 1 Anpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 2 ER/Outpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending after death.

Diractor: After din by the fur 1 Tes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death ordined at the fline, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cumpletely (Check only one) the 29b. Signature and of certifie 29c. License number 29d. Date signed (Month, Day, Year) torn's DECEMBER

Registrar

State

31. Date filed (Month, Day, Year)

CVE PITTLE

22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NONTH WEST

HIRISH.

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			1 - For State Registrar	Sta	ate of Ma	ryland		artmer					giene Reg. No	1116	3	9765
	Dhusia		1. Decedent's Name (First, Midd	le, Last)								2. Date of De	ath		3.	Time of Death
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	Cunaval		Alice Manor No 5. Social Security Number	ursing 6.Sex		(In yrs. las	t birthday)		Ltimo	re If Under	24 Hrs.	8. Date of Bir		ı/a	irthplace /	(State or Foreign
н	Funeral Director		085-07-4070	1□ M 2		89	Yrs.	Months		Hours	Min.	8/19/1	9 19°	Ma	Country)	State or Foreign
	2		Usual Residence of Decedent												- J = G-	
	ehow	5	10a. State 10b. County  MD n/a			10c. City, 7										side City Limits
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	be filed within 72 hours after death with the Maryland tal Hyglene.  d other then "natural", or items 23a or 28e-f ehow event, the Madical Exertine mast be notified at	Funeral Director	11. Marital Status	12. W	as Decedent Ev	ver in U.S.	13. 1			spanic Ori	gin? (Sp	ecify Yes or No		14. Race - An	-	dian
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N	Hygi Hygi ther int,		17. Father's Name (First, Middle,	Last)				ance		18 Mothe	r's Name	(First, Middle,		1 Home		
Maryland		To Be	Nick Till	10								Blase	79121307	ouname)		
ary	R D E E	_	19a. Informant's Name/Relations	ship (Type, Pr	rint)		19b. Mailir	g Address	(Street a			A Route Numbe	er, City o	or Town, State.	Zip Code	))
	1 and 2 Heelth a tem 27 is		David Toomey /	son								rnie, M				,
ore.	Se de la company		20a. Method of Disposition			20b. Plac	e of Dispo	sition (Nar	ne of			ate		ocation - City o		tate
Ĕ	Pages ment of the ent; if its ury or o		1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other (5		ai from State						2/16	/2006	G1er	n Burni	e. Ma	aryland
Baltimore,	permit. Page Department of Importent; if eny injury or otton.		21. Signature of Funer Service	Lipensee	1		22	. Name an	d Addres	s of Facility	y Amb	rose Fu	enra	al Home	of I	Lansdown
	g 0 5 9 9	0 //	- Ulun A	SILL	HUZL		27	19 H	ammor	nds F	erry	Road L	anso	lowne,	Mary1	land 2122
			23a. Part1. Enter the disease, o shock, or heart failure. List	complication only one cau	s that caused the se on each line	he death. [ ).	Do not ente	er the mod	e of dying	, such as	cardiac o	or respiratory ar	rest,		Appr	oximate val Between
,	Physician		Immediate Cause (Final disease or condition resulting in death)	a	De	mer	tre								Onse	et and Death
	/Medical Examiner		resulting in dealth)		Due to (or as a	consequen	ice of):			1.						
		7	Sequentially list conditions,	b	Due to for as a	rosm	CSW	C	120	ehi	~					
	nsit	i i	any, leading to immediate cause. Enter Underlying Cause (Disease or injury		1	Dich	0 (									
ý	cate be executed bhysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c	Due to (or as a	consequen	ce of):									
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89	ntifica ng ph	0	IF FEMALE:	1												
Вох	death certific e attending p id for use as i	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If y	res, outcome of Live birth 2	pregnancy Fetal de		Ectopic pr	egnancy					23d. Date of de	. ,	
0	0 0	SICI	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Pregnant at tir	me of death	n 5□	Other (sp						Month	Day	Year
Р. О.	that the died by the detached		Part II. Other significant condition	one contributi	ng to death but	not spoultin	a in the	alask dan a				02- Didde				
ds,	8 6 9	d b	[sethan	1. 2. (4.		cui d		idenying c	ause give	nın Parti.			es 2	Ise contribute t	o the caus	se of death?
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Re	The lav ete has page 2 :	Completed	- ayraa	-tun		_						24a. Was autop		24b. Were a prior to death?	utopsy fin comptetic	dings available on of cause of
<u>a</u>		ပိ	25. Was case referred to medica	W								1 ☐ Yes	20 No	1 🗆 Ye	s 2□ N	lo
>		ToB	examiner?	Hospita	l: 1  Inpatient	2□ ⊑0/	Outpatient	2 7 00	Other		/	Check only o			5	
Division of Vital Records,	g Phys er this eral di		27. Manner of Death		. Date of Injury	281	b. Time of		8c. Injury Work		sing Hor	8d. Describe h		6 □Other (Spe y occurred	ecity)	
ō	ath.	atlo	1 ☐ Matural 5 ☐ Pendir 2 ☐ Accident investi		(Month, Day Y	(ear)	Injury	М		es 2□N	10					
N	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		Place of Injury building, etc.	/ - At home (Specify)	, farm, stre	et, factory	, office		2	8f. Location (S City or Tow	treet an	d Number or A	ural Route	e Number,
	itel o rrs eft rei Di															
	To the Hospitel or Attending Phys within 24 hours eithe death. To the Funerel Director: After this crimpletely filled in by the funeral di	edical	29a. Certifier 1 Certifyir (Check only 2 Medical	Examiner: Or	To the best of an the basis of ex	xamination	dge, death and/or inv	estigation,	it the time	date and	placa a	nd dus to the d	ausa(s)	and manner a	s stated.	ause/s)
	thin 2 the mple	Med	one)  29b. Signature and title of certifie	airi	d manner state	d.			License							
	8 4 5 4		) ///X	W		W	1)7	230	_	314	64			e signed (Mon		edi)
	2		30. Name and address of person	who complets	nd cause of do-	th (Itam 22	a) (Tun- f	Print)			- '			,		
	.5		SHOALIS A. HI	Titor	22	( N	4 E V	TA.	2	- C,	nte	308	BA	LTIMO	NG 1	M17 2/20
	Sta	te	31. Date filed (Month, Day, Year)		32. Begistrar's	s Signature	-	A) -				11/13/2-2			15	
	Registr	ar	חדר 1	2006	France .	, K	40	BACK!								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year CSSI AM Dec Edgar Allen Trust 3006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd if Under HUTIMOVE INTORR 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) 77 Yrs. Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth (Month, Day, Year) 12-05-1929 9. Birthplace (State or Foreign Country)
Maryland Days Months 220-24-9031 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Baltimore Maryland Arbutus 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 925 Wilton Drive 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1949-1 □ Yes 2 No White Specify: 3 Widowed 4 □ Divorced 1953 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Draftsman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jarrett Herman Trust Amelia Scheidt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Trust, daughter 5208 Carroll Place <u>Baltimore</u>, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Veteran sor Cemerciace 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation p ☐ Other (Specify) Owings Mills, MD 12-14-06 Garrison Forest 21. Signature of Funeral Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Lo ber a Arbutus, MD. 21227 23a. Part1. Enter the disease, or complications that caused the dealth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final PULMONARY EMBOLUS house ITE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Sieces of Tight) that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural
Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Physician P.O. Box 68760, Records, Division or Vital

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran been signed be should be deta

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Examiner

Physician/Medical

by

Be Completed

Certification: To

Medical

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show apportant: If item 27 Is marked other than "natural", or items 23a or 28a-f show apportant; the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag

State Registrar 29b. Signature and title of certifier

4 ☐ Homicide

29a, Certifier

des mD and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1)0022648

150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

29d. Date signed (Month, Day, Year)

December 8, 2006

Jerome I. SNYDER M.D. 900 SOUTH CATON AVENUE BALTIMORE MARYLAND 21229 31. Date filed (Month, Day, Year) 32. signature

2006

		•	For State Registrar	State of Maryland		tment of H ificate of L			giene 2006	5 39767
			1. Decedent's Name (First, Middle, Las	"				2. Date of Dea Month	th Day Year	3. Time of Death
	Physicia /Medic		Elsie L	Tolberst.				12	06 200	101-11
}	Examin		4a. Facility Name (If not institution, give	street and number)	1 1	4b. City, Town, or	Location of Deat	h	4c. County of Dea	
			JUST STON	est Hospi	tal "	Rundi		222	Baltin	
	Funeral		Social Security Number     6. Se	TM 2ME	,, ,,	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	y, Year) 9. Bi	rthplace (State or Foreign country)
	Director		188-05-7800   Usual Residence of Decedent	8	8 Yrs.			04-01	-1918	PA
	and	-	10a. State 10b. County	10c. City	Town or Loca	ition				10d. Inside City Limits
	Aaryl f eho	ō	MD D 11:	T.	1 11					1 ☐ Yes 2 No
	28a-	ect	MD Baltimo	ore Ra	indall	S E OWD			10g. Citizen of What C	country?
	3a or	<u>a</u>	9717 Branchlei	.gh Road # 20	)2	211	133		US	A
	death The 2:	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S	6. 13. Wa	as Decedent of Hi	ispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - Am	
က	or Iter	교	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No				to Hican, etc.)	Black, Wh	
Ö	ral', c	ğ	3 Widowed 4 □ Divorced	If Yes, Give 12 Year or Dates:	10	JYes 2⊠No	Specify:			erican
21215-0036	72 h	Completed	15. Decedent's Ed (Specify only highest gra		(Give kii	nt's Usual Occupand of work done	during most of wo	rking	16b. Kind of Busines	
7	ithin	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DC	O NOT use retired	)		Wester	n Electric
2	led w tygier her tl	S	17. Father's Name (First, Middle, Last)	12th			18 Mother's Na	me (First, Middle,	Maiden Sumamel	1
ance Section	be fi	Be	Harold Parker				10. 141011161 3 144	me (r mai, middie,	warden Somanie,	unk
Maryland	hould d Mei mark matic	ဥ	19a. Informant's Name/Relationship (7	une Print)	19h Mailing	Address (Street :	and Number or R	ural Route Numbe	r City or Town State	Zip Code) 21133
Z Z	d 2 si th an 17 is r		Lisa Newton/Da							11stown, M
Ġ,	is 1 and 2 of Heelth a item 27 is other trau		20a. Method of Disposition	20b. Pl	ace of Disposit	tion (Name of	!	Date	20c. Location - City of	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show sayl injury or other traumatic event, the Michael Examina the notilinal at ance.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		utory or other plac ematory		7-06	Rol+imox	o MD
	artme ortan Injur		21. Signature of Figural Service Licen						Baltimor	Balto.Co.
Ba	permi Depa Impo eny Ir		12/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/	65					allstown	
		Н	29a Part 1. Enter the desease, pr comp	olications that caused the death						Approximate
	Physician		Shock, or heart failure. Vist only immediate Cause (Final		1	0	Λ \	7		Interval Between Onset and Death
1.	/Medical		disease or condition resulting in death)	a. Atheroscie  Due to (or as a consequ	ence of):	Corono	ind mute	nd nas	25	
	Examiner			b Long Can		•				
1		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):					
/	cuted nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	· Congesti		earst	Failo	re.		
Ö,	e exe		resulting in death) Last	Due to (dos a consequ	ence of):					
8760,	death certificate be executed e ettending physicien and id for use as the burial-transit	dlcai	•	d						
9 X	leath certifica ettending pt i for use as t	Physician/Medi	IF FEMALE:	23c. If yes, outcome of pregnar	201					
Box	ath c	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 □E	ctopic pregnancy Other (specify)			23d. Date of d Month	Day Year
		ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	30.	Ottion (specify)				
P.0	law requires that the es been signed by th 2 should be detache	4	Part II. Other significent conditions of	ontributing to death but not resu	Iting in the und	lerlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Records,	luires sign	d by						1 🗆 Y	′es 2 □ No 3 □ F	Probably 4 Ninknown
2	w require been signated should b	Completed						24a. Was	an 24b. Were	autopsy findings available completion of cause of
Be	0 - 0	E C						autop	med? death?	
of Vital	an: The tificete tor, pag	0	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only o		3 20110
$\leq$	Physician: this certificral director,	To B	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient	ER/Outpatient	3 DOA Oth	er: 4 🗆 Nursing	Home 5 ☐ Resid	lence 6 ☐Other (Sp	ecify)
0	ding Ph th. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Wor	y at k?	28d. Describe h	low injury occurred	
<u>.</u>	Attending r death. ector: After by the fune	atic	2 ☐ Accident investigation				Yes 2 □ No			
Division	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		et, factory, office		28f. Location (S City or Tow	Street and Number or i m, State)	Rural Route Number,
	urs af	S						1		
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	dicai		ysician: To the best of my knowniner: On the basis of examinat and manner stated.						
	ithin 2	Med	29b. Signature and title of certifier	and mainer stated.		29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
	F 3 F 8		1 Januar Land	foore 80		HOCF.	55644		19-06-	9006
	4	1	30. Name and address of person who		23a) (Tyne P	rint) .				
	7			Noviewast Hospi	tal 54	101 ad Co	Just Rd	Randall	stown MD	\$ 21133
	Sta	ate	31. Date filed (Month, Day, Year)	32. Segistrar's Signal		n _//=*				
	Regist	rar	DEC 1 4 20	06	K Red	and I				

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** 8, 2006 8:57A Randall Henry Tiedemann December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Harford 2105 Laurel Brook Road Fallston If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 **X**M 2 ☐ F Yrs 1946 Director 215-46-6835 60 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 le marked other than "natural", or Iteme 23a or 28e-f ehow other traumatic event, the Madical Examinar wast be notified at 1 ☐ Yes 2 No Director Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2105 Laurel Brook Road 21047 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. snt: If item 27 Ie marked other than "natural", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. 2 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Gas & Electric Co. Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Frona Joeckel Henry Albert Tiedemann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Tiedemann / Wife 2105 Laurel Brook Road, Fallston, Maryland 21047 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State ō permit. Page Department of Importent: If any injury or once. 4 □Donation 5 □ Other (Specify) Highview Memorial 12-11-06 Fallston, Maryland 22. Name and Address of Facility
McComas Funeral Home, P. A.
50 W. Broadway, Bel Air, Maryland 21014
Approximately 21. Signature of Funeral Service Licensee ussell Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** rolymphocytic months euxemia disease or condition resulting in death) /Medical Due to (or as a conseque) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed s certificate has been signed by the attending physicien and lirector, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 210 No 1 🗆 Yes After this certification Attending Physician: 25. Was case referred to medical 86 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deal To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide 0 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier at falillan - MID. December 11, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kasamon, M.S. 401 North Broadway, Battimore, Maryland 21231 Leslie 32. Registrar's Signature 31. Date filed (Month, Day, Year) State parti 1 4 2006 Registrar

			Please	State of	Maryland									
			1 - For State Registrar	Olato of	mar y tarre		rtificate					Reg. No.	2006	39769
			Decedent's Name (First, Middle, La	st)		-					2. Date of De		Year	3. Time of Death
М	Physicia /Medic		Edna Vogel							I	Decembe		2006	9:30a M
1	Examin		4a. Facility Name (If not institution, giv				4b. City,		Location of				County of Deat	
1			Milford Manor Nur  5. Social Security Number 6. S		Rehab . '. Age (In yrs. Ia	et hirthday)	If Under		svil		8. Date of Bir		Baltimo	
E	Funeral Director		1	M 20F	98	Yrs.	Months	Days	Hours	Min.	Jan 11	y, Year)		thplace (State or Foreign ountry) vland
	<u> </u>		213-48-9197 Usual Residence of Decedent				l				oun II	, 150	/O   Flat	
	arylar ehow	7	10a. State 10b. County  Maryland Baltimo	<b>*</b> 0		Town or Lo cesvil								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	Director	10e. Street and Number		1 1,0	CSVII	10f, Zip	Code				10a Citiza	en of What Co	L
	death with the Maryland ma 23a or 28a-f ehow r must be notified at	i Dir	4204 Old Milford	Mill Rd			101, 24	212	208			USA		, and y
	me 2	Funerai	11. Marital Status	12. Was Deced	ent Ever in U.S	5. 13.	Was Deced			gin? (Spe	cify Yes or No Rican, etc.)		4. Race - Ame	
9	after or Ite	/Fu	1 Never Married 2 ☐ Married	1 Yes 2	2 □ <sub>3</sub> No	1	1 ⊡Yes 2		Specify:	, rueno r	rican, etc.)		Black, Whit Specify: W	hite
S	be filed within 72 hours after death with the Marylan Hygione. d other than "natural", or Itema 23a or 28a-f ehow event, it a Madical Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Da	tes:									
5	in 72 nat	Completed	15. Decedent's E (Specify only highest gra	ade completed)		16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	il Occupa k done d e retired	ation furing most )	of workir	ng	160. Kin	d of Business/	Industry
212	r than	шо	Elementary/Secondary (0-12)	College (1-	4or 5+)		Labo					F	actory	
9	e filed wi al Hygien I other th vent, Its	Bec	17. Father's Name (First, Middle, Last,	)					18. Mother	r's Name	(First, Middle			
Maryland 21215-0036		10	UNKNOWN							IKNOW				
Mar	12 sho		19a. Informant's Name/Relationship (Charles M. Cahn,	** .	Ren		-					-	Town, State, 2	
e,	s 1 and 2 should if Health and Mer Item 27 is marke other traumatic		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Nam	ne of	į.		ate		ation - City or	
Baltimore,	a 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		tate	metery, crer don Pa			1	12/1	5/06			Maryland
	permit. Page Depertment Important: Il eny Injury o		21. Signature of Funeral Service Licer										uneral	
ñ	e de la companya de l		12	200	-	1.0								1 21229
			23a. Part1 Exter the disease, or com	plications that ca	used the death. ch line.	. Do not ent	er the mode	e of dying	g, such as o	cardiac o	r respiratory a	rrest,		Approximate Interval Between
1	Pnysician	i	Immediate Cause (Final disease or condition	· 13	1270	مع	25	1/2	cos					Onset and Death
	/Medical Examiner		resulting in death)	Due to (c	r as a consequ	ence of):								
		7	Sequentially list conditions, if any, leading to immediate	b. Due to (c	r as a consequ	ence of):								
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	0001010	. 45 4 55.15545	01100 017.								
· ·	te be executed ysicien and te burial-transit	Exa	that initiated events resulting in death) Last	Due to (c	r as a consequ	ence of):								
	ite be iysicie ne bur	Ical	(	_ d										
89	The law requires that the death certificate is hes been signed by the ettending physicage 2 should be detached for use as the t	by Physician/Medi	IF FEMALE:											
Вох	ath ce	ian/	23b. Was decedent pregnant in the past 12\months?		th 2 Fetal	death 3□	Ectopic pre					23	3d. Date of del Month	livery Day Year
o.	the de	ysic	1 □ Yes 2.2 No 9 □ Unknown	9□ Unkno	nt at time of de wn	ain 5L	Other (spe	өспу)						
<u>.</u>	w requires thet the de been signed by the should be detached	y Ph	Part II. Other significant conditions of			-	, ,	•			23e. Did t	obacco us	e contribute to	the cause of death?
rds	quires on sign	q pa	Bleer SI	erecti	c Cc	2011	2200	cla	1		10	Yes 2	No 3□Pr	robably 4 DUnknown
000	aw re	piet	VI.			Di	200	~			24a. Was		24b. Were at	utopsy findings available completion of cause of
		Completed									autor perfo	med3 2 2 No	death?	2 No
/ita	cian: ertific ector,	Be (	25. Was case referred to medical examiner?						-	of Death	(Check only o	опе)		
5	Physic this c	မ	1 □ Yes 2 No			R/Outpatier			4 Nur				Other (Spe	cify)
בס	Jing After	tion	27. Manner of Death  1 □Natural 5 □ Pending  Accident investigatio		, Day Year)	28b. Time of Injury	M 2	8c. Injury Work	rat c? Yes 2.⊟N		8d. Describe	now injury	occurred	
Division of Vital Records,	or Attendi after death. Director: A in by the fu	fica	3 Suicide 6 Could not b	e 28e. Place	of Injury - At hor	me, farm, str					28f. Location (	Street and	Number or Ri	ural Route Number,
á	al or A s after il Direct	Certification;	4 Homicide determined	buildin	g, etc. (Specify,	)					City or To	wn, State)		
	To the Hospital or Attanding Physician: within 24 hours state deals and or To the Funeral Director. After this certificacompletely filled in by the funeral director,	edicai (	29a. Certifier 1 Certifying Pt (Check only ane) 2 Medical Example	miner: On the ba	sis of examinati	vledge, deatl on and/or in	h occurred a	at the tim	ne, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) a date and p	and manner as place, and due	s stated. to the cause(s)
	within 2 To the complet	Mec	29b. Signature and title of certifier	and mann	er stated.		29c	. License	number			29d. Date	signed (Mont	h, Day, Year)
)	- s + ō		Musik	ler-	- 11		V	110	47 F	3		1	101	26
	10		30. Name and address of person who	completed cause	of death (Item	23а) (Туре,	Print)		, ,		1,	^		- 0
	6		4000010	J ( m	70	500	2	Y	Les	,0	16,	Lus	mi)-	21133.
2	Sta Registr		31. Date filed (Month, Day, Year)	006	gistrar's Signat	ure	ask)				`			
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			For State Registrar	State of Maryland / D	epartment of Heal Certificate of Dea		ental Hygien Reg. N	ZIIIIb	39770			
			Decedent's Name (First, Middle, Las	t)		2	2. Date of Death		3. Time of Death			
	Physicia /Medic		Joseph L.	Vrablik		[	December D	<sup>3</sup> 11 2006	04:00 AM			
)	Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Loca		4	c. County ol Death				
			1746 Banbury Roa			Island	B. Date of Birth	Anne A				
п	Funeral		5. Social Security Number 6. Security Number 143-05-7393	9X 7. Age (In yrs. last birth ▼ M 2□ F 88 Y	Months Days Ho	ours Min.	(Month, Day, Yea 10V. 06	1918 9. Birthp	lace (State or Foreign try) NJ			
-	Director		Usual Residence of Decedent	00			100. 00	1510	110			
	yland		10a. State 10b. County	10c. City, Town	or Location			1	0d. Inside City Limits			
	a-f	ct o	Florida Collier	Napl	es				1 ☐ Yes 2 🛣 No			
	ih th or 26	Dire	10e. Street and Number	7	10f. Zip Code		10g. C	itizen of What Cour	itry?			
	s 23s	rai		Ims Drive  12. Was Decedent Ever in U.S.	34113		fu Vee or No-	USA 14. Race - Americ	an Indian			
	item item	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces?	13. Was Decedent of Hispan If Yes, specify Cuban, Me		ican, etc.)	Black, White,	etc.			
92	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	1 Nyes 2 No If Yes, Give 942-45 Year or Dates:	1 ☐ Yes 2 🗓 No Sp	ecify:		Specify: Whi	te			
2	filed within 72 hours after death with the Maryland Hygiene. Hysiene. International control of the work inter the north of the work. The Madical Exactions internation inclined at	Completed	15. Decedent's Ed (Specify only highest gra		Decedent's Usual Occupation (Give kind of work done during	most of working	16b.	Kind of Business/In	dustry			
2	ithin	n jd	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)				_			
2	be filed within ntal Hygiene. of other than event, the Ma	S	12 17. Father's Name (First, Middle, Last)	2	Owner 18 I	Mother's Name (	First, Middle, Maide		Transport			
ä	B is b	Be c		rablik	101.							
Maryland 21215-0036	should be I and Mental I marked o	ဥ	GEONGE V  19a. Informant's Name/Relationship (7)	1 42 1 1 1	Mailing Address (Street and N	Mary Number or Rural			Code)			
	s 1 and 2 should if Health and Mer Item 27 le marke other traumatic		Anne G. Vrab	lik	427 Lely Palm	ns Drive	Naples.	FL 34113				
e,	of Hei		20a. Method of Disposition  1  Burial 2  Cremation 3	and at a s	Disposition (Name of y, crematory or other place)	Da	te 20c.	Location - City or To	own, State			
altimore,	Pages nent of ent: If it ury or o		4 Donation 5 Other (Specify	Metro	Crematory, Inc							
3alt	permit. Pages 1 Department of H Importent: If Ite any injury or ot		21. Signature of Funeral Service Licen	2	22. Name and Address of		allings F		me, P.A.			
	0 D ≥ € 0	$\square$	The South State of the State of	olice tons that caused the death. Do n	3111 Mountai			MD 21122	Approximate			
			shock, or heart failure. List only	on lause on each line.		23 3		100	Interval Between Onset and Death			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a compounce of):  Due to (or as a compounce of):									
	Examiner				н.ј.							
		Je.	Sacuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b.  Due to (or as a consequence of	nη:			_	-			
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87	The law requires that the death certificate be executed ate has been signed by the attending physicien and age 2 should be detached for use as the burial-transit	dicai		. d				- 1				
9 xo	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of delive	ery			
ğ	death a atter d for u	Physician/Med	in the past 12 months?	1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year			
о. О	by the de	hys	9 🗆 Unknown	9□ Unknown								
s,	res tha igned I be det	by F	Part II. Other significant conditions of	ontributing to death but not resulting in	Part I.	_	ne cause of death?					
ord	w requir been si should	ed ed					1 Yes	2√DNo 3□Prot	pably 4 □Unknown			
Records,	e law has b	Completed					24a. Was an autopsy performed?	24b. Were auto prior to co death?	psy lindings available impletion of cause of			
alF							1 □ Yes 2 🗗		21 <b>9</b> (No			
Ξ	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	Othor		(Check only one) e 5 ☐ Residence	6 MOther (Special	Daughters			
o	g Phy er this eral d	<b>-</b>	27. Manner of Death	28a. Date of Injury 28b. T	ime of 28c. Injury at Work?		3d. Describe how in		Residence			
jo	Attending r death. ector: Alter by the fune	atio	1 Natural 5 Pending 2 Accident investigation	1	M 1 ☐ Yes	2 🗆 No						
Division of Vital	or Attend ter death Irector: n by the	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28	Bl. Location (Street City or Town, Sta		al Route Number,			
Ω	Hospital or 24 hours afte Funerel Dir tely filled in		One Continue AMOn within the	To the book of the standards	4-11-1-1-1-1			(-) d				
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical		ysician: To the best of my knowledge niner: On the basis of examination and and manner stated.								
	To the within 2 To the comple	Me	29b. Signature and title of certifier	11 -	29c. License nur	mber	29d. 0	ate signed (Month,	Day, Year)			
	, , , ,		10,60	Drahmo M	DONS	1770	Do	combo	-122011			
	12		30. Name and address of person who	completed cause of death (Item 23a) (	Type, Print)	_ ; _ ;	2 ( )	11	y 122004 y land 21231			
	15		Julie R. Br.	shower, MD 16	50 Orleans	Street	- Beltix	novellar	y land 21231			
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature	M. 6				1			
DU	MH 17 Rev 1/2		DEC 1 4 2006	BORNES SI JUNE								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Of Maryland / Department of Health and Mental Hygiene Of State affect of Death Registrer Certificate of Death Registrer 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dayth **Physician** DECEMBER 200 /Medical 4c. County of Death Examiner KANDAI 15 to WIN If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month, Day 5. Social Security Number 9. Birthplace Country) **Funeral** 231-14-282 Usual Residence of Decedent Yrs. Director death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f ahov any Injury or other traumatic event, the Medical Examinar must be notified at once. 1 Yes 2 No **Funeral Director** 380/5 10g. Citizen of What Co Was Decedent Ever in U.S. Armed Forces?

1 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during Kind of Busines Plementary/Secondary (0-12) College (1-4or 5+) 17. Fath Name (First Middle, Las ROBINSON (DAUC) 19b. Mallin, Add 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EREBRO VAS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Certification; To Be Completed by Physician/Medical page 2 should be detached for use as the IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 Yes 1 ☐ Yes 2 No within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, j 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 N Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2006

State Registrar 06

GINDER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

1- State Amend #5, perFH, G862, 12/14/06 TT

Certificate of Death

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MAURICE WARD 2:22 DEC 12 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 25 2-10 :06 Director 6.01.1941 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director Middle Miver 10g. Citizen of What Country? 10e. Street and Number . Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surhame) un Known Unknam 17. Father's Name (First, Middle, Last) Be ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scamon Ave Baltimore MD 21225 Maurice Ward, Jr. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Crematory 12.15:06 (Baltimore, m) Vaughn C Greene June at Service Vaughn C Greene June at Service \$778 Liberty Rd Randall Stun mo HB3 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GEREBRO VASCULAL ACCIDENT **Physician** disease or condition resulting in death) /Medical Examiner CHRONIC NEUTROPHILLIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and as the burial-transit ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 by Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PAPILLARY THYROID 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed RENAL 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 20 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospita within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9831 DEC 12 2006 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. GREENE BALTIMOTE. 31. Date filed (Month Pay Year)
14 32. ₽egistrar's Signature State 2006 work! Registrar Deserve .

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrer	State o	f Maryla		artment <i>rtificate</i>			Mental Hy	gier Reg. M	2000	39773
E	Physici		1. Decedent's Name (First, Middle George D. W.	a anev						2. Date of De Month Decembe	0	Day Year 11 2006	3. Time of Death 8:14 PM
	/Medic Examir		4a. Facility Name (If not institution,		mber)		4b. City, To	own, or l	Location of Deal	-		4c. County of Death	0
			Baltimore Wash	ington Me					Burnie			Anne Ar	
	Funeral Director		5. Social Security Number 219-52-3333	6. Sex 12 M 2□ F		s. last birthday) 58 Yrs.	If Under 1 Months I	Year Days	Hours Min.	(Month, Da	av. Yea	9. Birthy Cou	place (State or Foreign ntry) MD
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. C	City, Town or Lo	ocation	-					10d. Inside City Limits
	a-fet	to	Maryland Anne	e Arundel				P	asadena				1 ☐ Yes 2 ☐ No
	ith the	Oire	10e. Street and Number				10f. Zip C	ode			10g. (	Citizen of What Cou	ntry?
	• 23a	rai	651 209th Stre		dank Garain	11.0	W D	-A -616-	21122			USA	and the disc
920	be filed within 72 hours after death with the Maryland ital Hygiene.  do other then "naturel", or iteme 23a or 28a-f ehow event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marri 3 □ Widowed 4 ☑ Divorced	12. Was Dece Armed Fo ed 1 Tes If Yes, Giv Year or D	rces? 2⊠No 'e		Was Deceder II Yes, specify 1 ☐ Yes 2	y Cuban	panic Origin? (S , Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	)-	14. Race - Americ Black, White, Specify: W	
21215-0036	72 ho	Completed by	15. Decedent			16a. Dece	dent's Usual (	Occupat	ion	rkina	16b.	Kind of Business/In	idustry
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/lan	should be filed within of Mental Hygiene. marked other then imatic event, the M	To Be		Wagner					Margare		, 7412104	Fitzpatr	ick
<u>~</u>	Peges 1 and 2 : ent of Health ar nt: if item 27 ie ry or other trau		19a. Informant's Name/Relationsh Jarod T. Wagner	ip <i>(Type, Print)</i> ( SO	n)					ural Route Numb A Sadena,		y or Town, State, Zip 21122	Code)
Baltimore,			20a. Method of Disposition	2 Dame attende		Place of Dispo	sition (Name matory or other	of er place	Doo	Date 1.6	20c.	Location - City or Town, State	
			1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sc		Me Me	etro Cre			, Dec	. 16 006	Bal	timore, N	Maryland
Ball	permit. Peg Department Important: any injury o		21. Signature of Fune & Service L	igende			2. Name and		ی	tallings 1. Pasad	Fu ena	neral Hom , MD 2112	ne, P.A.
			23a. Part1. Enter the disease, or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Constructions and Posts										
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90,	icate be executed physicien and the burial-transit		resulting in death) Last	Due to (	of as a conse	equence of):		• •					
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	v		30. Name and address person v	lus us	e f death (Ite	m 23a) (Туре,	Print)	1			0 20	2010 - 011	0
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	Sta Registr		DFC 1 4	2006	oyiotiai s olgi	lature design	rate)					21061	,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Α. White 2006 9:13  $a^{\mathsf{M}}$ Marjorie December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist 8. Date of Birth (Month, Day, Ye Nov. 10, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1. 1926 **Funeral** 1 ☐ M 2 🔀 F 80 Pennsylvania Director 213-20-3854 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore 1 □Yes 2 No iral", or items 23a or 28a-f sh Examiner must be notified Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 USA 8305 Oakleigh Road Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: White 3 ☐ Widowed 4 X Divorced Completed er than "natur , the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Meat Wrapper Grocery Item 27 Is marked othe other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Mary Warg William Youngman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10 Kirsim Court Freeland, Md. 21053 Mr. H. Dennis White/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Discurial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or 12-14-06 Moreland Mem. Park Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home
1050 York Rd. Towson, Md 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Lach line. Approximate Interval Between Onset and Death Immediate Cause (Final emorringic **Physician** neak disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine little cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the buria Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an ate has bage 2 s autopsy performe certificate 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Yes 2 | 1√10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? after death.

I Director: After to in by the funeral 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours af

To the Funeral D

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of deat (item 23a) (Type, Print) les St. Bolto MI Zo208

State Registrar 31. Date filed (Month, Day, Year)

DEC 1 4 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygier 👂 🛭 🗎 🖯 39775 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Hattie Winder 3:56 p Dec 6, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Sinai Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M X □ F Yrs. **Director** 219-62-2359 66 So. Carolina Apr 23, 1940 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 is marked other than "naturel", or items 23a or 28a-f show treumatic event, the Medical Examinar must be notified at Director Baltimore 1XYes 2 ☐ No Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2325 Hollins Street - 214 21223 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Š Black 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hotel Clerk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H tent: If item 27 Is marked other: Robert Gasque Sr Almeta Gasque 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1002 Wedgewood Road Baltimore, Maryland 21229 Yvonne Matthews Daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 № Burial 2 Cremation 3 Removal from State injury or permit. Page Department of Importent: If any injury or once. \* 4 ☐ Donation \_5 ☐ Other (Specify) 12/11/06 Baltimore, Maryland Arbutus Memorial Park 21. Signature of Pyrieral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypoxemic Respiratory Failure Physician days /Medical Due to (or as a consequence of): & Examiner 16 years Fibrosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>Pulmonary</u> Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medlcal the IF FEMALE use a 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗌 Yes 2 **X**No 1 Yes Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient Certification: To 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred or Attending After 1 Natural Injury 5 Pending 1 TYes 2 TNo investigation after death Director: / 2 Accident 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a: To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 6, 2006 of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital 2. Registrar's Signature State 4 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 10, 2006 **Physician** Rita Avis Weddle 1:05 P /Medical 4a. Facifity Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Four Seasons Assisted Living Bel Air Harford 8. Date of Birth (Month, Day, Yea. Mar. 30, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6 Sex Birthplace (State or Foreign Country) **Funeral** Days Year 1 M 2 XF Hours 94 Director 1912 Virginia 215-50-7791 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be obtified at 1 Yes 2 No by Funeral Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 1301 A. Sheridan Place Items 23a 21015 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo ō Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: 3 🔀 Widowed 4 □ Divorced White natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Caleb (unk) Branscome Rhoda (unk) Dalton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health Nowell T. Weddle / Son 324 Maitland Street, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department of Important: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Grdn 12-16-06 Bel Air, Maryland 22 Name and Address of Facility
McComas Funeral Home, P.A 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Coman Priysician 0, URAN /Medical Due to (or as a consequence of) Examiner SD 5-cuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a codsequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. for use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 3 Probably 4 Unknown 1 Tyes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 20 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Pface of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Living 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director; A the 3 Suicide 6 Could not be in by t 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical ZU Medical Examinery on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and Iffe of certi 29d. Date signed (Month, Day, Year) 29c. License number December 12 2006 30. Name and address of perion who completed cause of death (Item 23a) (Type, Print)

LNOA FULLULT (0) E Weel 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

			cate of L	Death	a wichtar	7.0	g. No. 200	3977	
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last) Darren Lee Anderson				2. Date of Death Month December		3 Time of Death 2357 hrs	
-	4	4a. Facility Name (if not institution, give street and number)	4b	. City, Town, or	Location of Dea		4c. County of Death		
	Î	New Market- Turner Road		Mechanicsv			St. Mary's		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs last bir		If Under 1 Year Months Days		lin	h(MM/DD/YYYY) 9. Bir Foreig	n	
Director		215-25-5284 1 M 2 F 18	Yrs.			Januar	y 12, 1988°	<sup>untry</sup> Maryland	
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	n or Location	1				10d Inside City Limits	
× .	_	Maryland St. Mary's	M	lechanic	sville			1 Yes 2 X No	
Aaryland 28a-f show Latonce,	Director	10e Street and Number		10f. Zip Code		10	g Citizen of What Cour	ntry?	
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er dea	Fun	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 N	es 2X No	specify:		Specify: Whi	to	
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21215-0036 hould be filed within 72 and Mental Hygiene is marked other than stic event, the Medical	9 9	Daniel Lee Anderson  19a Informant's Name/Relationship (Type, Print )  19	9b. Mailing A	Address (Stree	Denise t and Number of	Lynn Sha r Rural Route Num	anks ber, City or Town, State	, Zıp Code)	
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 nent of Health and Nental Hygiene nant: If item 27 is marked other than ' or other tranmatic event, the Medical		1 Nourial 2 Cremation 3 Removal from State crema	atory or othe	on (Name of cer r place)		ecember	20c. Location - City or		
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Baltimore, permit. Pages l ar Department of Hee Important: If itel		21. Signature of Funeral Service Licensee	22. Nar	me and Address	of Facility $\mathrm{Br}$	insfield-	Echols F.H	.,P.A.,	
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/Medical		failure List only one cause on each line.		, 3.		,		Between Onset and Death	
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	nine	if any, leading to immediate cause Enter Underlying Cause  (Crease or highly that initiated cause)							
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Box e death c the atten	Physician	1 Yes 2 No 9 Unknown 9 Unknown	5 Othe	er (Specify)			ti.		
* 4 % 49		Part II. Other significant conditions contributing to death but not resulting	ng in the un	derlying cause g	given in Part I.		bacco use contribute to		
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	2	A CALL THE CONTROL OF CONTROL		O.C.I			29d Date signed (Moi		
		30. Name and address of person who completed cause of death (Item 23a)	)	3.3.					
300		Margarita Korell MD. Assistant Medical Examiner	,	nn Street, B	altimore, MI	21201			
	tate	31 Date filed (Month, Day, Year) 3 Registrar's Signature	1. 4						
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State of Maryland / Department of Health and Mental Hygierie 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** Victoria **Alexander** 6:30 A 11/26/2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Hyattsville ST. Thomas More Nursing Home Il Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 69 239-62-4334 1 M 2 N F Yrs. 8/23/1937 Charlotte, NC Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir then "netural", or Items 23a or 28e-f ehow the Micical Examiner must be notified at Y Yes 2 No Directo Prince George's Landover 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20785 USA 1411 Bellehaven Dr. death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Baltimore, Maryland 21215-0036 Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Private permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie. Importent: if Itam 27 ie marked other ti any Injury or other traumatic event. Its once. 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ethe1 Price Victor Alexander ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1411 Bell Haven Drive Landover, Maryland 20785 Jason Blackman/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Riverdale Crematory 11/28/2006 Riverdale, Maryland 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 ☐ Donation \_ 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licenses Landover, MD 20785 7474 Landover Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction **Physician** /Medical Due to (or as a consequence of). Examiner Hypertensive Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ol) Examine Atherosclerotic Cardiovascular Disease ettending physicien and for use es the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ф detached 9 Unknown 9 Unknown ete hes been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Be Completed End Stage Renal Disease 24b. Were autopsy lindings available prior to completion of cause of death?
1 ☐ Yes 24≦ No 24a. Was an certificete hes 1 Tyes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 Yes 2 No his After this funeral of 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c, Injury at Work? 27, Manner of Death Certification: or Attending 5 Pending investigation 1 🖾 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 27, 2006 D0051122 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1160 Varnum Street N.E. Washington, DC 20017 Esmerando O. Juanitez M.D. 31. Date filed (Month, Day, Year) NOV 2 8 2006

Registrar DHMH 17 Rev 1/2001

State

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** November 23,2006 Corrinne E. Ashlin 6:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1507 Marlbourgh Court Crofton Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. June 12, 1923 1 □ M 2 🔽 F 579-32-6140 Texas 83 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifled at Crofton 1 ☐ Yes 2 ☐XNo Director MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1507 Marlbourgh Court 21114 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 XNo Baltimore, Maryland 21215-0036 White ģ 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Day Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmslie Harry Sadie Souder ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun once. John Davies Ashlin 1507 Marlbourgh Court Crofton, MD 21114 Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Nov.25,2006 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hardesty Funeral Home P.A. 851 Annapolis RD 21054 Dat 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatio years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leaf cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the aftending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed funeral director, page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performe 1∐ Yes 2 No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide tacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. 29b. Signature and title decertifier 29d. Date signed (Month, Pay, Year) ess of perso 30. Name and add n who completed ause of death (Item 23a) (Type, Print) Mitchellville 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 Registrar Z NOV LUUO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 29 A M Margaret Jean Asquith 2006 /Medical Chember 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ton Melical Haguith, Margo Anne Hrunde Changarie ride de somitale If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min. 1 □ M 2 X X 65 Feb 24 1941 Maryland Director 214-40-7497 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. and the them 27 is marked other than "natural", or items 23a or 28a-f show ant: if item 27 is marked other than "natural", or items 25a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Director Annapolis Anne Arundel MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21409 1185 Hampton Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or Noif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXNo Baltimore, Maryland 21215-0036 Specify White 3XXVidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Child Development Daycare Provider 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgana Flood Albert Kleeberg ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: if item 27 is
any injury or other trau 301 Poplar Avenue, Edgewater, MD 21037 Joseph Mattison (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11-27-2006 Annapolis, MD Hillcrest Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signature of Funeral Service. Jala 12 Ridgely Avenue, Annapolis, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner SEVER Aci DOSI Sequentially list conditions ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical as attending p use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 □Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4. Unknown 2 □ No 3 ☐ Probably 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 21-No 2 1 No 1 ☐Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ၉ 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Tsion Berhane, MD Hospital Drive, Glen Burnie, MD 21061 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2006 State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** $P^{M}$ Beatrice Adviotis November 21, 2006 1:40 /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🔀 F 87 Vrs 214-18-3882 Director May 5, 1919 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and them than "naturel", or Items 23s or 28e-f show ant: If item 27 is marked other than "naturel", or Items 23s or 28e-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland 10e. Street and N rel', or Items 23a or 28e-f show Examiner must be notified at Anne Arundel Annapolis 1 XYes 2 ☐ No 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21403 #17 U.S.A. 695 Americana Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2, 100 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes & No Specify: White à 3X7Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other treumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cashier 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William C. Katsereles Christina Lewnes 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret A. Connor/niece 378 Long Meadow Way Arnold, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State Demetrios Cemetery 11/27/2006 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Juneral Ber 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Causestive Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician Physiclan/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ prossure 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 25. Was case referred to medical examiner? 1 ☐ Yes 2 ◯ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 27. Manner of Peath 1/2 Natural 2 Accident 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, spitel or Attending Physicien: Thours after death.
unerel Director: After this certification thilled in by the funeral director, pa within 24 hours a To the Funerel I To the Hospitel

Baltimore, Maryland 21215-0036

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifie Constrying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title o completed cause of death (Item 23a) (Type, Print)

State Registrar \_0

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

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			1- State of Marylan		artment of H		Mental H	lygiene Reg. No	C 0 0 0	39782
	Dhusiei	210	Decedent's Name (First, Middle, Last)				2. Date of	Death		3. Time of Death
	Physicia /Medic	al	Lynne Ader		4h City Town o	A continue of Doo	Novemb		2006 County of Dea	4:50 a M
	Examin	er	4a. Facility Name (If not institution, give street and number)  Brighton Gardens Assisted Livin	œ	4b. City, Town, or Chevy Cha		ın			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)			8. Date of	Birth	ntgomer	hplace (State or Foreign
	Director		082-16-2845 1□ M 2XF 85  Usual Residence of Decedent	Yrs.	monand bays	1,00.0	Dec.	.87, 19	20 New	York
	land ow			y, Town or Lo	ocation					10d. Inside City Limits
	a-f eh	ctor	Maryland Montgomery Che	vy Cha	.se					1 ☐ Yes 2 ₹ No
	deeth with the Maryland ms 23a or 28a-f ehow r myst be notified at	Director	10e. Street and Number		10f. Zip Code			10g. Cit	izen of What Co	puntry?
	eeth v	Funeral	5555 Friendship Blvd.  11. Marital Status 12. Was Decedent Ever in U.	S 13 1	20815	isnanic Origin? (	Snecify Yes or		ed Stat	
0	ufter d	Fun	Armed Forces?	- 1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No		to Rican, etc.)		Black, White	e, etc.
9500-c	uret', c	d by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Year or Dates:		1 Yes ZEINO	Specify:				
2	n 72 h	lete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wo	orking	16b. K	ind of Business	Industry
7 7	d withi	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Homem	aker	,		0wn	Home	
2	be filed within 72 hours after dial Hygiene. disher than "naturel", or item event, ite Madical Examination.	Bec	17. Father's Name (First, Middle, Last)			18. Molher's Na	me (First, Mid	dle, Maiden	Sumame)	
Maryland	nould I	Tol	Irving Abbott	105 14-15	Add (Ca)	Charlot			- T C4-4-	To Control
<u>8</u>	id 2 st Ith end 27 is n traun		19a. Informant's Name/Relationship (Type, Print)  Joel Ader-Son		ng Address <i>(Street a</i> Ordway SI					cip Code)
ē,	f Hee		20a. Method of Disposition 20b. P		osition (Name of matory or other place		Date 27-2006	20c 1	ocation - City or	Town, Stale
Ē	Page ment c ant: if ury or	0	I C Bunai 2 Excremation 3 C Hemovar nom State	ropoli	tan Crema	torv		Alex	andria,	
baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiens. Department of Health and Mental Hygiens "naturel", or items 23a or 28a-f show many injury or other traumatic event, the Marylan Examinar mant be notified at once.		21. Signatule of Fundal Service License	22 P	ike, Rock	ss of Facility S: ville, N	imple T D 2085	ribut O	e, 1040	Rockville
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	n. Do not ent	er the mode of dyin	g, such as cardia	c or respirator	y arrest,		Approximate Interval Between Onset and Death
	Pnysician /Med <del>i</del> cal		Immediate Cause (Final disease or condition resulting in death)  aCongestive ]		Failure					2 Years
	Examiner		Due to (or as a conseq	Jence or):						
	ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	uenea at):						
	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C	uence of):						
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٥	rtificat ng phy as th	ed	IF FEMALE:							
X P P	death certificate e attending physi d for use as the	Physician/M	23b. Was decedent pregnant 23c. If yes, outcome of pregna	Ideath 3□	Ectopic pregnancy				23d. Date of de Month	ivery Day Year
j.		yslc	in the past 12 months? 1   Yes 24   No 9   Unknown	eath 5	Other (specify)					
J.	law requires that the de: as been signed by the a 2 should be detached f	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							he cause of death?
cords	w require been si should t	ted	Atrial Fibrillation				1	☐ Yes 2	Ω No 3 □ Pi	obably 4 Unknown
Ř	The ate h	Completed	Alzheimer's Disease			·	24a. W a p 1 □ Ye	utopsy erformęd?	prior to death?	itopsy findings available completion of cause of 2 No
VITA	Physician: The this certificate har all director, page	Be	25. Was case referred to medical examiner?  1   Yes   2   Xes   Hospital: 1   Inpatient   2		oth 3C DOA Oth	26. Place of De				
ō	d is	n; To	27. Magner of Death 28a. Date of Injury	28b. Time of	" 00 000	- Indianig	Home 5 ☐ R 28d. Descri			cityAssisted Living
<u>ö</u>	ath. or: Afte	atlo	2 Accident investigation	Injury		K? Yes 2 □No				
DIVISION	s efter de si Directo al Directo	Certification:	3 Suicide 6 Could not be delemined 28e. Place of Injury - At h building, etc. (Specification)	ome, farm, sir y)	reet, factory, office		28f. Localid City or	n (Street ar Town, State	nd Number or Ri	ural Route Number,
	To the Hospital or Attending Pr within 24 hours elter death. To the Funeral Director: Atter it completely filled in by the funeral	Medical	29a. Certifier (Check only one)  1	wledge, death lion and/or in	h occurred at the lin vestigation, in my o	ne, date and plac pinion, death occ	e, and due to urred at the tin	the cause(s ne, date and	and manner as place, and due	stated. lo the cause(s)
	To t To tl	Σ	29b. Signature and title of certifier		29c. Licens				te signed (Mont	
•			met we, mo		D6012	9		1	127/2	.006
	10		30. Name and address of person who completed cause of death (Item Brent Cole, M.D., 5530 Wisconsin	n Avenu	ie, # 730	, Chevy	Chase,	MD 20	)815	
7.	Sta Registr		31. Dale filed (Month, Day, Year)  NOV 2 9 2006  32 negistrar's Signa	y A	arti)		<u>-</u>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 22,2006 2:15A **Physician** PHILLIS Μ. ASHBURNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS LA PLATA CENTER LAPLATACHARLES 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral 1 M XX Yrs. 79 Director 227-32-2333 NOV.13,1927 VIRGINIA Usuat Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b County 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1**X**Xes 2 ☐ No Be Completed by Funeral Director CHARLES LA PLATA MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 109 OUAIL COURT 20646 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 ō 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: If item 27 is marked other th
eny injury or other traumatic avent, tha 12 4 **HOMEMAKER** OWN SELF 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHNNY MITCHELL ESTER CREEMUR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WAYMAN ASHBURNE-HUSBAND 109 QUAIL CT., LA PLATA, MARYLAND 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Squrial 2 Cremation 3 Removal from State | Cemetery, crematory or other place)
4 Donation 5 Other (Specify) ROOSEVELT MEMORIAL PK. 11-29-06 CHESAPEAKE, VA M00479 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiat or respiratory arest, 6 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DUANCILA Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, physicien IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should be Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 1 ☐ Yes 2 ☐ No 2 X No funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medicai Certification: To 1 ☐ Yes 2 💢 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending within 24 hours efter death.

To the Funerei Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one)

State Registrar 29b. Signature and title of certifier

30. Nome a did ess of person

R CVZ

2006

DHMH 17 Rev 1/2001

o completed cau e of death (Item 23a) (Type, Print) ATK

32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Yea

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene.

39784

For State Of Waryland / Dep	ertificate of Death	Reg. No.
	7 - 7 - 7 - 7	ber 28 20% 1018 M
		4c. County of Death Wicomico
5. Social Security Number  6. Sex 7. Age (In yrs. last birthda)  11 M 2 F  80 Yrs.		Birth Pearl 9. Birthplace (State or Foreign Country)
10a. State 10b. County 10c. City, Town or	1	10d. Inside City Limits 1 □ Yes 2
10e. Street and Number 23662 LesliE TRENT Rd.	10f. Zip Code 23421	10g. Citizen of What Country?
11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married   12 No   14 s, Give Year or Dates: 1960	. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes 2 No Specify:	r No- ) 14. Race - American Indian, Black, White, etc. Specify: BLACK
(Specify only highest grade completed) (Giv	re kind of work doné during most of working . DO NOT use retired)	16b. Kind of Business/Industry  Chrysler  Corporation
17. Father's Name (First, Middle, Last)  ELMER RICRNETT	18. Mother's Name (First, Mic	ddle, Maiden Surname)
19a. Informant's Name/Relationship (Type, Print)  Sherwood White (Step Son) P.O.		ımber, City or Town, State, Zip Code)
1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	mc Cem, 12/2/06	20c. Location · City or Town, State Whitesville, WA
21. Signature of Funeral Service Licensee	Bennie Smith Sunferal Home Salis	sbury md 21801
23a. Part1. Ever the disease, or complications that caused the death. Do not e shock, or heart failine. List only one cause on each line.	nter the mode of dying, such as cardiac or respirato	ry arrest. Approximate Interval Between Onset and Death
Due to (or as a consequence of):	-	
that initiated events c.		
d.		
		23d. Date of delivery  Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the	Did tobacco use contribute to the cause of death?  These 2 No 3 Probably 4 Unknown	
	a	prior to completion of cause of death?
25. Was case referred to medical examiner?	26. Place of Death   Check or	nly one)
27. Manney of Death  1 ② Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c, Injury at 28d, Descr	ibe how injury occurred
4 Homicide determined 288. Place of injury - At nome, tarm, so building, etc. (Specify)	on (Street and Number or Rural Route Number, Town, State)	
(Check only 2 Medical Examiner: On the basis of examination and/or one) and manner stated.	investigation, in my opinion, death occurred at the ti	me, date and place, and due to the cause(s)
) G Mn	00062916	29d. Date signed (Month, Day, Year)
	- D (-4)	
30. Name and address of person who completed cause of death (Item 23a) (Typ.  SVET AND GATT CAREZ (V.1.5  31. Date filed (Month, Day, Year)  32. Peristrar's Signature	SOUTH GIVISION SHIT	7 & SOR ISBURY MO 21804
	Registrar  1. Decedent's Name (First, Middle, Last)  WALTER GROSS BUR  4a. Facility Name (It not institution, give street and number)  Peninsula Regional Medical Center  5. Social Security Number  5. Social Security Number  5. Social Security Number  6. Sex  10a. State  10b. County  VA ACCOMACK  10c. Street and Number  2. Social Security Number  2. Social Security Number  3. Social Security Number  3. Social Security Number  3. Social Security Number  3. Social Security Number  4. Social Security Number  3. Social Security Number  3. Social Security Number  3. Social Security Number  3. Social Security Number  3. Social Security Number  3. Social Security Number  4. Social Security Number  5. Social Security Number  5. Social Security Number  6. Sex  12. Was Decedent Ever in U.S.  13. Tather's Name Number  12. Was Decedent Ever in U.S.  13. Tather's Number  15. Decedent's Education  (Specify only Ingrised grade completed)  16. Social Security Number  17. Father's Name (First, Middle, Last)  18. Ingrised Security Number  19. Manual Security Number  19	Decedent's Name (First, Middle, Last)   Decedent's Name (First, Midlle, Name (First, Midlle, Name (First, Midlle, Name (First, Midlle, Name (First, Midlle, Name (First, Midlle, Name (First, Midlle, Name (First, Midlle, Name (First, Midlle, Name (First, Midlle, Name (First, Midlle, Name (First, Midlle, Name (First, Midlle, Name (First, Midlle, Name (First, Midlle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) BAILE Day Year Month **Physician** 100 PM 06 /Medical (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAlis bue 406 CranE Koad If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday)
55 Yrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreig Country) **Funeral** Days Hours Min. Months 1 □ M 20 F 216-56-175 Director nce of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-1 show any injury or other traumatic event, If a Mudical Example in must be notified at 1 Yes 2 □ No Nicomico Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code S.A 406 8 Dad Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 BLACK Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+) Production aboror 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Briscoe BAILEY Ohn oth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 30813 ANNR 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Comm. Minity Venton 4 □ Donation 5 □ Other (Specify) Cem 25 Signature of Funeral Service 22. Name and Address of Facility 917 W. Isabella St Bennie Smith SAIS bury, my 2,800 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Intervat Between Onset and Death Immediate Cause (Plaat disease or condition resulting in death) **Physician** mod cal /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of) Examine ed by the attending physician and detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical tF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed 1 ☐ Yes 25 No 1 Yes 2 No director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) Director: After this 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours after To the Funerel Dire To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number

Registrar

30. Name and address of person wh

31. Date filed (Month, Day, DEC

Steadman

Year)

2006

DL. C

DHMH 17 Rev 1/2001

**ORIGINAL** 

Speak

mt. Vernow load Princess Anne

maryland

no completed cause of death (Item 23a) (Type, Print)

32. Pagistrar's Signature

Director    State	3. Time of Death 2:30 A. M  seath y's  Birthplace (State or Foreign Country)  In State State of Foreign  Country?  Country:  C
Physician / Medical Examiner  David Bielawski  December 1, 2006  4a. Facility Name (if not institution, give street and number)  16086 Murray Road  Funeral Director  Funeral Status  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Director  Funeral Status  Funeral Director  Funeral Director  Funeral Status  Funeral Director  Funeral Status  Funeral Director  Funeral Director  Funeral Status  Funeral Director  Funeral Status  Funeral Director  Funeral Director  Funeral Status  Funeral Director  Funeral Director  Funeral Status  Funeral Director  Funeral Status  Funeral Director  Funeral Director  Funeral Director  Funeral Status  Funeral Director  Funeral Director  Funeral Status  Funeral Director  Funeral Dire	2:30 A. M  asath  y's  Birthplace (State or Foreign Country)  In 1s, France  10d. Inside City Limits 1 yes 2 No  Country?  Lates  merican Indian, hite, etc.  Thite  ss/Industry  Law Firm  a, Zip Code)  180
## Familiner  4a. Facility Name (If not institution, give street and number)  16086 Murray Road  5. Social Security Number  578-40-4545  15 Mary s	seath  y's Sirthplace (State or Foreign Country) ITIS, France  10d. Inside City Limits 1   Yes 2 No Country? Sates merican Indian, hite, etc.  Thite ss/Industry  Law Firm  o, Zip Code) 180
The color   The	Sirthplace (State or Foreign Country)  ITIS, France  10d. Inside City Limits 1  Yes 2 No  Country?  Lates  merican Indian, hite, etc.  Thite  ss/Industry  Law Firm  p. Zip Code)
Funeral Director    Social Security Number   Social Security Security Number   Social Security Number   Social Security Number   Social Security Number   Social Security Number   Social Security Number   Social Security Number   Social Security Number   Social Security Number   Social Security Number   Social Security Number   Social Security Number   Social Security Number   Social Security Number   Social Security Number   Social Security N	Arithplace (State or Foreign Country)  ITIS, France  10d. Inside City Limits 1 Yes 2 No  Country?  Sates  merican Indian, hite, etc.  Thite  ss/Industry  Law Firm  2. Zip Code)  80
Director    State	10d. Inside City Limits 1  Yes 2 No  Country?  ates merican Indian, hite, etc.  Thite ss/Industry  Law Firm
The proof of the part of the p	1   Yes 2 No  Country?  ates merican Indian, hite, etc.  Thite ss/Industry  Law Firm
1   Never Married   2   Married   1   Yes   2   No   Specify:	Country? Lates merican Indian, hite, etc. Thite ss/Industry  Law Firm  Descript Code)
1   Never Married   2   Married   1   Yes   2   No   Specify:	nates merican Indian, hite, etc.  Thite ss/Industry  Law Firm  p. Zip Code)
1   Never Married   2   Married   1   Yes   2   No   Specify:	merican Indian, hite, etc.  Thite ss/Industry  Law Firm  p. Zip Code)
1   Never Married   2   Married   1   Yes   2   No   Specify:	hite, etc. Thite ss/Industry Law Firm sp. Zip Code)
Henri Bielawski  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State  Christa L. Rielawski/Wife  16086 Murray Road Ridge Maryland 206	Section Sectin Section Section Section Section Section Section Section Section
Henri Bielawski  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State  Christa L. Rielawski/Wife  16086 Murray Road Ridge Maryland 206	Law Firm  a. Zip Code) 80
Henri Bielawski  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State  Christa L. Rielawski/Wife  16086 Murray Road Ridge Maryland 206	9, Zip Code) 80
Henri Bielawski  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State  Christa L. Rielawski/Wife  16086 Murray Road Ridge Maryland 206	9, Zip Code) 80
Henri Bielawski  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State  Christa L. Rielawski/Wife  16086 Murray Road Ridge Maryland 206	80
	80
	80
Christa L. Bielawski/Wife  Christa L. Bielawski/Wife  16086 Murray Road, Ridge, Maryland 206  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  Date  20c. Location - City	omi, ciato
1 Burial 2 Cremation 3 Removal from State  1 December  1 December  1 December  1 December  1 December  1 December  1 December  1 December  1 December  1 December  1 December	e Hall, MD
20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   December   20c. Location - City	Home, P.A.
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Physician Immediate Cause (Final disease or condition	Onset and Death
/Medical resulting in death)  Due to (or as a consequence of):	1
Sequentially list conditions b.	
d. La la be expressed to the property of the p	
The second secon	
X	delivery Day Year
to a g   tes z ling	
9 Unknown  9 Unknown	to the cause of death?
	Probably 4 Johknown
24a. Was an autopsy prior	autopsy findings available o completion of cause of
	?
25. Was case referred to med examiner?	
The state of the s	pecify)
27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending 28b. Time of Injury Work? 1 Yes 2 No 28b. Time of Injury Work? 1 Yes 2 No	
To the part of the	Rural Route Number,
27. Manner Death    Section   Color	
29a. Certifier (Check only (Ch	as stated. ue to the cause(s)
and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Mo. ) 34/188	nth, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
David Federle, 24035 Three Notch Road, Hollywood, Maryland 20636	
State Registrar  State Registrar	

Certificate of Death

3. Time of Death

12:16p

 Birthplace (State or Foreign Country) Pittsburgh, PA.

29d. Date signed (Month, Day, Year)

November 22, 2006

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

10d. Inside City Limits 1XYes 2 No

									rieg. No.		
	Decedent's Name	(First, Middle, L	Last)					2. Date of De			3. Time of D
Physician /Medical	JEVON	C.	BL	AKEMORE				Nov.	<sup>Day</sup> <b>21</b>	2006	12:16p
Examiner	4a. Facility Name (If r	not institution, g	ive street and nun	nber)		4b. City, Town, or		4c. Cour	nty of Death		
	Holy Cros	s Hosp	ital			Silver	Spring		Mor	itgome	ry
Funeral	5. Social Security Nur		Sex	7. Age (In yrs. las:	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bir (Month, Da	th	9. Birth	place (State or I
irector	193-64-00	)31	14 M 2 F	32	Yrs.	Months Days	Hours Min.			Pitt	sburgh,
	Usual Residence of D	Decedent					,				
를 놓	10a. State	10b. County		10c. City, 7	Town or Lo	cation					10d. Inside City
tor stor	MD	Montgo	mery	1	Rockv	ille					1 Yes 2
be notified Director	10e. Street and Number					10f. Zip Code			10g. Citizen of What Country?		
al D	3836 Park Lake Drive					2085		USA			
Iner must Funeral	11. Marital Status		12. Was Dece	edent Ever in U.S.	13. V	Vas Decedent of Hi	spanic Origin? (Sp	ecify Yes or No		ace - Ameri	
	1 Never Marrie	I 1 ☐ Yes	1 ☐ Yes 2 ☐XNo		<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.</li> <li>Yes 2 XNo Specify:</li> </ol>			) Black, White, etc.		etc.	
b Exam	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:				1	☐ Yes 2 🛣No	Specify: Black		lack		
t, the Medical Ex Completed b	15. Decedent's Education 16a. Dec (Specify only highest grade completed) 1 (Giv				16a. Deced	ent's Usual Occupa	ation	16b. Kind of	16b. Kind of Business/Industry		
Med a	Elementary/Secondary (0-12) College (1-4or 5+)				life. L	kind of work done o OO NOT use retired	arry				
a e	12th							Cheese	Cheesecake Factory		
event, the Be Con	17. Father's Name (F	irst, Middle, La	st)				18. Mother's Nam	e (First, Middle	, Maiden Surna	ame)	
atic evaluation of the state of	Robert T. Blakemore					Gwendolyn Reid					
is marked o aumatic eve To Be	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  3836 Park Lake Drive									Code)	
27 is	Gwendoly:	Blake	more/Motl	her		Park Lak ville, MD				, , ,	,
oth	20a. Method of Dispo			20b. Plac	e of Dispos	sition (Name of natory or other plac	e)	Date	20c. Location	- City or To	own, State
int: if	1 XBurial 2 ☐ 4 ☐ Donation 5		$\square$ Removal from $s$	State		Heaven	i	8-2006	Silver	Spri	ng, MD.
permit. P Departme Importan any injur once.	21. Signature of Fund	eral Service Lic		1 10	22	Name and Addrese arshall's	s of Facility			Spri	ng, r

**Physician** /Medical Examiner

Examiner attending physician and for use as the burial-tran Completed by Physician/Medical ed by the a Be 2 Certification:

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Medical

State Registrar

A. P.I	4217 9th St. N.W.	Washington, DC 20	0011
shoet, or heart failure. List	complications that caused the death. Do not enter the mode of dying, such as cardiac only one cause on each line.	or respiratory arrest,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	Cardiac Arrhythmia		instant
resulting in death)	Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. — Due to (or as a consequence of):		
that initiated events resulting in death) Last	C. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of d Month	elivery Day Year
	ons contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
Hypertension		1 ☐ Yes 2 ☐ No 3 ☐ F	Probably 4 XJnknov

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3X DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

Injury 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

26. Place of Death (Check only one)

24a. Was an autopsy performed?

1 Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

8609 Second AVe #404B Silver Spring, MD. 20910

29c. License number

D28656

31. Date filed (Month, Day, Year)

NOV 28 2006

Ravi Passi, M.D.

d title of certifier

Diabetes Mellitus

25. Was case referred to medical examiner?
1 ☐ Yes 2 ♣No

27. Manner of Death

1 Xatural

2 Accident

3 Suicide

29a. Certifier

29b. Signature e

4 ☐ Homicide

Intracranial Hemorrhage

5 Pending investigation

6 Could not be determined



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2006 9:27 a M Ethe1 Μ. Brown Nov. 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Holy Cross Hospital Montgomery Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 13 F Director 77 March 23, 1929 Maryland 21524-1133 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shoredical Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be It 20904 3142 Gracefield Road, MG504 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: δ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Martin Sadie Mae Stephans မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Brown/Daughter 6006 Hosta Court, Elkridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 11/29/06 Brentwood, MD of Furjeral Service Licensee Port Lincoln Funeral Home, 3401 Bladensburg Rd. Brentwood, MD 20722 21. Signatu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Failure Day resulting in death) /Medical Due to (or as a consequence of): **Examiner** Pulmonary Hypertension Week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ospital or Attending Physician: The law requires that the death certificate be executed hours after death.

Hours after death.

Universi Director: After this certificate has been signed by the attending physician and yif illed in by the funeral director, page 2 should be detached for use as the burial-transit yif illed. Exami Intestinal Pulmonary Fibrosis Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Renal Insufficiency 1 Yes 2 No 3 Probably 4√DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? /es 2 🖾 No 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 1 🔀 Inpatient Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral D 1X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

31. Date filed (Month, Day, Year NOV 28 2006

29b. Signature an



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D24035

29d. Date signed (Month, Day, Year)

November 26, 2006

20904

		For State Registrar		State of Ma	aryland		partment of F ertificate of		and Me	-	_			
Physici		Decedent's Nam		,	DDT			Doutin		2. Date of De Month	Da	y Yea	( N	
/Medic Examir		4a. Facility Name (	BERNIC  If not institution, g	E IRENE give street and number)	BRI	CE	4b. City, Town, o	r Location o		Novemb		27 , 200 c. County of De		
Funeral Director		Frederic 5. Social Security N 214-28-1	Number 6	ial Hospita Sex 7. Agr	11 e (In yrs. Ia	a <i>st birthd</i> Yrs	Months   Days		24 Hrs. 8 Min. A	B. Date of Bir (Month, Da pril l	th	rederi 923 Ma	ck Birthplace (State or Foreig Country) aryland	
and w		Usual Residence of	f Decedent 10b. County		10c. City	, Town o	Location						10d. Inside City Limits	
Maryl I-f sho fled al	tor	Maryland	Freder	ick	Th	urmo	nt						1 Yes 2 No	
th the or 28a e noti	Director	10e. Street and Nu		-			10f. Zip Code				10g. Ci	tizen of What	Country?	
ath wi	ral	214 West	: Main St				217					USA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Mar 3 ☑ Widowed	ried 2 Married 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 Xi If Yes, Give Year or Dates:		S.   1	13. Was Decedent of F If Yes, specify Cub 1 ☐ Yes 2 No	lispanic Ori an, Mexicar Specify:	gin? (Speci n, Puerto Ri	ity Yes or No ican, etc.)	-	14. Hace - Ar Black, WI Specify:	nerican Indian, hite, etc. White	
"natu	etec	(Spe	15. Decedent's cify only highest	Education grade completed)		16a. De	ecedent's Usual Occup live kind of work done fe. DO NOT use retired	ation during mos	t of working	7	16b. k	(ind of Busines	ss/Industry	
within iene. than the Me	Completed	Elementary/Sec	ondary (0-12)	College (1-4or 5	i+)		e. DO NOT use retired .cer/ Hand				Sho	e Manuf	facturing	
al Hygin other	BeC	17. Father's Name	(First, Middle, La	ıst)						First, Middle,				
ould b Ments arked attc e	To E	Steven			Gr	een			rtha		Live		Green	
and 2 sh ealth and m 27 is m her traum		19a. Informant's N Richard E	Brice/So			3 S	ailing Address (Street andy Sprin	and Numbers	rt Ap	t #7	Thu	rmont,	MD 21788	
Pages 1				□Removal from State ecify)	Ce	emetery,	pate 20c. Location - City or Town, State remaiory or other place) 7 en Mem. Gards 11/30/06 Frederick, MD 21702 22. Name and Address of Facility Stauffer Funeral Home, PA							
permit. Depart Import any inj		23a. Party Egrer the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest.												
Physician /Medical		23a. Part Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a											Approximate Interval Between Onset and Death	
Examiner	ier	Sequentially list co if any, leading to in cause. Enter Und	onditions, mmediate	b. Due to (or as										
ficate be executed physician and s the burial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):												
eath certificate be executed attending physician and for use as the burial-transit	edical													
To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	2 months?	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	/				23d. Date of o	delivery Day Year	
quires that in signed b uld be deta	by			s contributing to death b				ren in Part I		23e. Did t			to the cause of death?  Probably 4 □Unknown	
The law re e has bee age 2 shor	Completed										psy prmed?	prior t death	autopsy findings available o completion of cause of	
ian: 7 rtificat xtor, pi	Be C	25. Was case refe	erred to medical					26. Place	of Death (	1□ Yes Check only o	one)	0 1LJY	es ধ No	
hysic this ce	To E		140	Hospital: Inpatie			itient 3 DOA Oth	4 L Ni	ırsing Home	e 5□Resi	dence	6 □Other (S)	pecify)	
tending P eath. or: After the funera	ation:	27. Manner of Dea	5 ☐ Pending investiga	the	y Year)	28b. Tim Inju	ry Woi M 1□	yat k? Yes 2□		d. Describe	how inju	iry occurred		
ital or Att rs after d ral Direct led in by	Certific	27. Manner of Death  27. Manner of Death  28. Date of Injury  (Month, Day Year)  28. Injury at Work?  1								City or Tou	wn, Stat	'e)	Rural Route Number,	
he Hospi in 24 hou he Funer pletely fill	Medical	29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physician: To the best xaminer: On the basis o and manner sta	f examinat	wledge, d tion and/o	eath occurred at the ti or investigation, in my	me, date ar opinion, dea	nd place, ar ath occurred	nd due to the d at the time,	cause(s date ar	s) and manner nd place, and d	as stated. lue to the cause(s)	
To t To t	Ž	29b. Signature an	d title of certifier	hma			29c. Licens	577	76				onth, Day, Year) - 27, 2086	
\		30. Name and add	rma 400	ho completed cause of d  No. Sevent	h Str	eet	Frederic	k, MD	2170	1				
St Regist	ate rar	31. Date filed (Mo	NOV 3 (	2006 32. Registr	ar's Signa	ture	Spelle							
							1							

			For State Registrar	State of Mary			of Health a of Death		F	Reg. No.	006	397	
п	Physici /Medic		1. Decedent's Name (First, Middle, La Marjorie Leola					l l	2. Date of Dea Novembe	er <sup>Da</sup> Ž2,	<b>,</b> 2ੴ6	3. Time of De 9:47 A	
k T	Examin		4a. Facility Name (If not institution, giv Carroll Hospital			Westn	wn, or Location o inster			1	unty of Death		
	Funeral Director		312-20-0373	ex 7. Age (In □ M 2□xF 81	yrs. last birthday, Yrs.	If Under 1 \ Months D	ear If Under lays Hours	Min.	June 1		Cour	place (State or Fo ntry) nth Bend	1.5
000	-f show	tor	Usuel Residence of Decedent  10a. State 10b. County  MD Carro.	_	: City, Town or L Vestmins						1	0d. Inside City L	
di di	a or 28s	Direc	10e. Street and Number 225 Frock Dr.,	Apt 314		10f. Zip Co				10g. Citizen	of What Cou	ntry?	
1215-0036	should be lied within to hous are bean with the mayer and Mental Hygiene. The Mental Hygiene has "neturel", or leme 23e or 28e-f show imatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	in U.S. 13.		t of Hispanic Ori Cuban, Mexican		ify Yes or No- ican, etc.)	14.	Race - Amend Black, White,		
Maryland 21215-0036	ine. Ihan "neture Medical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give	DO NOT use i	tone during mos	st of working	9		of Business/In	dustry	
and 2	ital Hygi d other	To Be Co	12 17. Father's Name (First, Middle, Last John McNaughtor		HOM	emaker			First, Middle,	Maiden Sui	n Home mame)		
Mary	t Health and Menitem 27 ie marke		19a. Informant's Name/Relationship ( Judith Lorch –	Type, Print) Daughter			treet and Number						
Baltimore,	nent of Hea Int: If item Iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia	Removal from State	Db. Place of Disponentery, cre Carroll	matory or othe	r place)	11/27 nc.	2006		ion - City or To		
Balti	Department of important: If i any injury or one		21. Signature of Fundal Service Lice	es -	Pı	ritts F	uneral i	412 Wa	ashingt & Chare	בן ועוב	l.	2115 ter, MD	7
760,	hysician hysician and hysician and hysician and hysician and hysician sit partial transit	licai Examiner	23a. Part 1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  5. Counties of the condition of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cord.)  Due to (or as a cord.)  Due to (or as a cord.)	death. Do not en	ter the mode o	f dying, such as	cardiac or	respiratory ar	rest,		Approximate Interval Betweet Onset and Dea	
.O. Box 68	y the attending phy ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregi ⊒ Other (speci				23d	. Date of delive Month	ery Day Yea	r
rds, P.	ine law requires mai me de ste has been signed by the a page 2 should be detached f	ρ	Part II. Other significant conditions	contributing to death but no	t resulting in the o	underlying caus	se given in Part I	l.	23e. Did to		•	he cause of deat	
Il Records,		Completed							24a. Was autop perfor 1 Yes	rmed?	4b. Were auto prior to co death? 1  Yes	ppsy findings ava mpletion of caus 2 No	ılable e of
Vita	s certific director,	To Be	25. Was case referred to medical examiner?	Hospital:	2 ☐ ER/Outpatie	nt 3□ DOA	Other		(Check only o		Other (Specif	(v)	
Division of Vital	Attending Frigstcian: The releath.  ector: After this certificate he by the funeral director, page		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of		Injury at Work?	28	3d. Describe h			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Divis	e # 5 ⊆	Certification:	3 Suicide 6 Could not be determined		At home, farm, si pecify)	reet, factory, o	ffice	26	Bf. Location (S City or Tow	Street and N vn. State)	lumber or Rura	al Route Number	
:	within 24 hours after or within 24 hours after To the Funerel Dir completaly filled in it	Medicai	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	nysician: To the best of my miner: On the basis of exa and manner stated.	knowledge, dea mination and/or i	th occurred at investigation, in	the time, date an my opinion, dea	nd place, an ath occurred	nd due to the o	cause(s) and date and pla	d manner as s ace, and due to	tated. the cause(s)	
		W	29b. Signature and title of certifier	. 0		29c. L	icense number			29d. Date si	igned (Month,	Day, Year)	
	WIL		30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print) $SF 3$	07 613	()Och		1112	0 21	(57	
3	Sta Regist		31. Date filed (Month, Day, Year)  NOV 2 8	32. Registrar's S	Signature	Soul!	,		141.216	7. (			

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	/larylan	d / Depa		t of H	ealth a			iene	06	39791
	Physici	an	1. Decedent's Name (First, Middle, La Margaret	ist)	TQ.	enton			-		2. Date of Dea Month	Day .	Year	3. Time of Death
	/Media	cal							73 N-2		Noveni	T		9.30 PM
1	Examir	ner	4a. Facility Name (If not institution, given Millennium Hea						Location o					
	Funeral					last birthday)	If Under	1 Year	If Under 2		8. Date of Birth	Date of Death Month Day Year Volunte 18 206  4c. County of Death Howard  Date of Birth (Month Day Year Volunte 18 206  4c. County of Death Howard  Date of Birth (Month Day Year Volunte Volun	place (State or Foreign	
	Director		Usual Residence of Decedent	1□M 2 <b>X</b> □F	84	Yrs.	Months	Days	Hours	Min.	Nov. 25	, T921	Vir	ginia
	anylar ehow	_	10a. State 10b. County			y, Town or Lo							1	0d. Inside City Limits
	28a-f	ecto	Maryland Char  10e. Street and Number	les	In	dian						0-022	400	1 ☐ Yes 2 ☐ No
	with	by Funeral Director	2960 Old Donca	ster Pla	ace.		10f. Zip	206	<i>4</i> ∩					ntry ?
	death ms 23	era	11. Marital Status	12. Was Deceder	nt Ever in U.	.S. 13. \	Nas Deced			jin? (Spec	cify Yes or No-			can Indian,
9	or ite	표	1 ☐ Never Married 2 🙀 Married	Armed Force 1 Yes 2 If Yes, Give	s? ≹No					, Puerto F	Rican, etc.)			etc.
003	ural',	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates	3:		1 □ Yes	ZICI NO	Specify:			Specify	Whi	te
215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f ehow the Modical Examiner must be mutified at	lete	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	dent's Usua kind of wor DO NOT us	k done a	luring most	of workin	ng	16b. Kind of B	usiness/In	dustry
212	withii iene. than	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)		pela			ler		II S	Cove	rnment
	nould be filled within a Mental Hygiene. narked other than natic event, Itle M	Be C	17. Father's Name (First, Middle, Last	)			рста				(First, Middle,			FIMICITE
/ar	uid be Menta rrked ritic ev	To B	Hudson A. Mc	Neil					Na	nnie	L. Os	borne		
Maryland	and		19a. Informant's Name/Relationship			1								
	1 and 2 Health tem 27		Thomas G. Bent	on Hus	oand	8695	Gil	roy	Rd.	, Na	njemoy			
Ö	ges 1 If of F if its or of		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐		200. P	lace of Dispo emetery, cren	natory or o	ne or ther place	Nov	. 24,	2006		•	
Baltimore,	it. Pa rtmen rtent: njury		* 4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Sice		Tr	unity	Mem	orı	al G	arde	ens V		i, M	aryland
Ba	permit. Pages 1 an Department of Heal importent: if item 2 any injury or other QDCE.		market	lla 1	10066	8 4	270	Haw	thor	ne_R	d., Ir	ndian	Head	20640 , Md.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart ailur. List only Immediate Cause (First disease or condition resulting in death)	a. A Mu Due to (or a	line.			, ,			_			Approximate Interval Between Onset and Death
3760,	eath certificate be executed attending physician and for use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a	is a conseq	uence of):								
P.O. Box 68	The law requires that the death certificate be executed the seen signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  O 9  Unknown	23c. If yes, outcom 1□Live birth 4□Pregnant 9□Unknown	2 ☐ Feta at time of d	Ideath 3□	Ectopic pro							ory Day Year
	quires that n signed b uld be deta	ed by Pi	Part II. Other significant conditions	contributing to death	but not res	ulting in the ur	nderlying ca	ause give	n in Part I.					
Records,	The faw require sate has been si page 2 should b	Completed		· · · · · · · · · · · · · · · · · · ·				·			autops perforr	y ned?	rior to cor leath?	csy findings available inpletion of cause of
Vital	i <b>clen:</b> Th certificate rector, pag	Be (	25. Was case referred to medical examiner?						26. Place	of Death	(Check only on	8		
of \	Physicien: this certificatal director, p	은	1 ☐ Yes 2 ☑ No			ER/Outpatien			4 LaPRUIT	-				)
Division o	ding After fune	Certification:	27. Manner Death  1 Natural 5 Pending  2 Accident investigatio  3 Suicide 6 Could not be		Day Year)	28b. Time of Injury	М		at ? ′es 2 □ N			. ,		
Divi	P Sir E	Certifi	4 Homicide determined	building,							City or Town	, State)		
	To the Hospital within 24 hours a To the Funerel Completely filled	edical	(Check only 2 Medical Exal	niner: On the basis	of examina	tion and/or inv	estigation,	in my op	inion, deat	h occurre	d at the time, d	ate and place, a	and due to	the cause(s)
	With To t	Σ	29b. Signature and title of certifier	<u>a</u> .			29c	License	number		2	9d. Date signed	(Month,	Day, Year)
•			7	Vul				DE	5066	+1		Novenl	ul 1	1 200 6
1	DB7		30. Name and address of person who Ramus San	apalm	death (Item	23a) (Type, 1	Ba	ck	River	Nee	k Ro	ad Bo	rllem	p Mayford
	Sta Registr	ite rar	NOV 2 9	2006 32. R	trar's Signa	J. J.	book	,						-

			For Amen#19A Peir FH State Registrar 11/27/06 AACC	State of Marylan		artment of F		nd Mental Hy	/giene	06	39792
			Decedent's Name (First, Middle, Last					2. Date of D	eath	V	3. Time of Death
	Physici /Medic		VIRGINIA VOCCIA B	URCH				Month	mer 33	and	6:25 A M
	Examin		4a. Facility Name (If not institution, give	street and number)  U Center	•	4b. City, Town, o	ata	Death	4c. County	of Death	3
	Funeral		5. Social Security Number 6. S	□M 2B7E		If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, D	irth lay, Year)	Count	
*	Director	}	039 05 6552 Usual Residence of Decedent	8	3 113.			09–06-	-23	RHODE	ISLAND
	/land		10a. State 10b. County	10c. City	, Town or Lo	ocation				10	d. Inside City Limits
	Man	ģ	MARYLAND CHARLES	WALD	ORF						1 ☐ Yes 2 No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Count	ry?
	ath wi		2009 ST. THOMAS DR	IVE APT.308		20602			UNITED S		
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?		Was Decedent of H If Yes, specify Cuba	lispanic Origi an, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)		e - America ck, White, e	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify	WHITE	
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other than "naturel", or Items 23a or 28a-f ehow remarke event, Ita Medical Examinar must be notilied at	edt	15. Decedent's Ed		16a. Dece	dent's Usual Occup	pation		16b. Kind of B		
215	nin 72	Completed	(Specify only highest gra		(Give	kind of work done DO NOT use retire	during most of	of working			•
212	d with	E O	12	2	ADMIN	ISTRATIV	E ASSI	STANT	DEPARTM	ENT OF	THE INT.
bu	al Hy toth	Bec	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (First, Middle	e, Maiden Suman	ne)	
Va	Ment Ment arked	일	GENNARO VOCCIA				ANNA	MILONE			
Maryland	ges 1 and 2 should be filed within 72 hc t of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, Its Medical		19a. Informant's Name/Relationship (		1			or Rural Route Numi		State, Zip	Code)
6	and tealth im 27 her t		CHARLES E. HAGAR	(FRIEND-EXECUT		AY STREE	T LON	GMONT, CO.	80501 20c. Location -	City of Toy	on State
Baltimore,	If its		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐	Removal from State	emetery, cre	matory`or other pla					
計	rt Pa		4 □Donation 5 □Other (Specification 21. Signature of Lune at Section 21.	() KAL		MATORY Name and Addre		-26-06 GEORGE P.	EDGEWATI		
Ba	permit. Pages 1 and 2 Department of Health a Important: if item 27 ie eny injury or other tra:		) distribution	The name of the sa				LAND ROAD			D. 21037
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	one cause on each line.		•			arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition			dia In					00/5
1	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	1	10.001	Diseas	0		Years
		-	Sequentially list conditions,	b. Die to for as a nonseci		Cry PIP	RICAL	1013840	2	_	
	pet nslt	Examiner	Sequentially list conditions, if any, leading to instruction cause. Enter Underlying Cause (Disease or injury		active cry						
	execu end al-tra	xar	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):						
8760,	cate be executed physicien end ; the burial-transit	cal		d.							
9	ifficati g phy as the	edic									
Вох	h cer endin	N/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	incy I death 3	Ectopic pregnanci	v			te of deliver	•
	The law requires that the death certific tie has been signed by the attending p page 2 should be deteched for use as:	Completed by Physician/Medi	in the past 12 months? 1 □ Yes 2 □No 9 □ Unknown	4☐Pregnant at time of di 9☐ Unknown		Other (specify)	,		МС	onth (	Day Year
P.0	that t	y Ph	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use cont	tribute to the	a cause of death?
sp.	uires sign lid be	Ď.	Hypertensia	n, Bread Mellitus	Cance	1, Ast	ama	10	Yes 2□No	3 🗆 Proba	ably 4 DUnknown
00	w req	lete	Diabetes.	Mellitus,	HYPOT	zyro idi	JM	24a. Wa	s an 24b.	Were autop	sy findings available
Re	The la	E O						auto	rormeg?	prior to com death? 1 ☐ Yes ::	sy findings available apletion of cause of
ta	un: T	BeC	25. Was case referred to medical				26. Place of	1 ☐ Yes of Death (Check only		10.165	20140
<b>\</b>	Attending Physician: r death. sctor: After this certifica by the funeral director.		examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 XInpatient 2□	ER/Outpatie	nt 3 DOA Off	ner: 4 🗆 Nurs	sing Home 5 Res	sidence 6 🗆 Oth	ner (Specify,	)
0 4	ng Pt fter th neral	Ë	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injui	ry at rk?	28d. Describe	how injury occur	red	
Sio	eath. or: A	catle	2 Accident investigation 3 Suicide 6 Could not b				Yes 2 N				
Division of Vital Records,	or Att	rtiff	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st y)	reet, factory, office			(Street and Numb own, State)	oer or Rural	Route Number,
_	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funers! Director: After this certificate has completely filled in by the funers! director, page 2	edical Certification: To	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	ysician: To the best of my kno niner: On the basis of examina	wledge, deat	h occurred at the timestration in my	me, date and	place, and due to the	e cause(s) and ma	anner as sta	ated.
	To the H within 24 To the F complete	Medi	one)  29b. Signature and title of certifier	and manner stated.	220.11	29c. Licens			29d. Date signe		
	5 th 02	2	29b. Signature and title of certifier	Sindrum!		29C. Licens			-	4/06	*
						10	MIA		6.23	7/	4)
	5		30. Name and address of person who	completed cause of death (Item	n 23a) (Type,	JC EII. (11117	Pent	skoop 20	* DUH	30	4
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa		V	MULLI	FI MU	apuro.	<u></u>	
1	Regist		NUV 27	2006	di da	back .					

06-09282 M

lvin Bumbrey		State of Maryland / Dep		f Health an				200	6 20701
Physicia		1. Decedent's Name (First, Middle,Last)	Crimodic or	Dodin		2. Date of [			3. Time of Death
edical Examir	ner	Melvin Bumbrey					ber 5, 2		2122 hrs
		4a. Facility Name (if not institution, give street and number)  Southern Maryland Hospital		4b. City, Town, or Clinton	Location of De	eath		County of Dear	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs 579 – 72 – 5760 1 1 4 2 F 53	s. last birthday) Yrs	If Under 1 Yea  Months Day			18/ 18/	For	Birthplace (State or eign Country)
eath with the Maryland items 23a or 28a-f show any ust be notified at once.	I Dire	Md Prince George  10e. Street and Number 5516 Vernon Way  11. Marital Status 1 Never Married 2 X Married Armed Forces?	If Y		spanic Origin?			White, etc.	erican Indian, Black,
215-0036 be filed within 72 hours after death with the Maryland mal Hygiene rked other than "natural", or items 23a or 28a-f she rent, the Medical Examiner must be notified at once	mpleted by	3 Widowed 4 Divorced If Yes 2 No. 3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  1 2 th  17. Father's Name (First, Middle, Last)	1 16a. Deceder during m	Yes 2X No nt's Usual Occupations of working life -Employ	tion (Give kind DO NOT use ed	of work done retired) ame (First, Midd	F	Kind of Busines	lack ss/Industry Restaurant
도 교육 열하	Be	Oscar Bumbrey  19a. Informant's Name/Relationship (Type, Print )	19b. Mailing	g Address (Stree	Sussi	ie Cuse	enbe:	rry	ate, Zip Code)
MD d 2 sho th and n 27 is		Patricia Bumbrey Wife		5 Verno	n Way	Suitla	and,		46
Baltimore, MC permit. Pages 1 and 2 s Department of Health at Important: If item 27 injury or other traums		1 K Burial 2 Cremation 3 Removal from State	ort Lir	her place) ncoln	12	Date 2/12/06	6 B:	rentwo	od, Md
Balti permit. Departin Importi	8	21. Signature of Funeral Service Licensee  January  23a. Part I. F. ter the disease, or complications that caused the dec	14	409 Fai	rlakes	s Pl St	te B	Mitc	rvice, PA hellville,
Physician /Medical Examiner	Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e of):	lar diseas	e with s	evere val	vular	disease	Between Onset and Death
Box 68760, e death certificate be executed the attending physician and led for use as the burial - transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of properties of the past 12 months?  1 Unknown  23c. If yes, outcome of properties of properties of the past 12 months?  25c. If yes, outcome of properties of pro	2 Fe	etal death 3 ther (Specify)	Ectopic pre	egnancy		d. Date of deliv Month	Day Year
Records, P.O. The law requires that th cate has been signed by page 2 should be detach	ompleted by	End stage renal disease, diabetes	-			1 24a. W	Yes 2	No 3 P	
sion of Vital I trending Physician: death ctor: After this certifi y the funeral director,	Certification: To Be C	25. Was case referred to medical examiner?  1  Yes 2  No  Hospital: 1 Inpatient 2  27. Manner of Death 1  X Natural 5  Pending Investigation 2  Accident  Investigation 3  Suicide 6  Could not be determined  (Specify)	ER/Outpatient 28b. Time of I	t 3 DOA	ry at Work? Yes 2 No	28d. Descri	ibe how inj	ury accurred	her: Rural Route Number, City
Divis  To the Hospital or A within 24 hours after To the Funeral Dire	Medical Co	29a. Certifier 1 Certifying Physician: To the best of my know one) 2 Medical Examiner: On the basis of examination and manner stated							
E % E 8	Me	29b Signature and title of certifier  Losha Leef ALD		29c, Licens O.C.				Date signed (ficember 6, 2	Month, Day, Year)
		30. Name and address of person who completed cause of death (I Tasha Greenberg MD. Assistant Medical Exa		Penn Street,	Baltimore,	MD 21201			
St	tate	31. Date filed (Month (Near) 32. Registrar's Sign	nature	make 9					

			1 - For State Registrar	State of M	laryland		artmen rtificat			and M	-	giene Reg. Na	006	35	1794
	Dhysia		1. Decedent's Name (First, Middle, La	st)						1	2. Date of De	ath			ne of Death
	Physici /Medi			RGER							NOVEMBER	26, 2	2006 Year	10	0:42A M
	Examir	ner	4a. Facility Name (If not institution, give		7)		4b. City,	Town, or	Location o	f Death		4c. C	County of Deat	th	
			HOLY CROSS HOSPITA  5. Social Security Number 6.5		20 (la la	and the Control of the Control	If Under		SPRIN				NTGOMER'		
	Funeral Director			7. A	ge (In yrs. Ia 90	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da AUG. 12,	th y, Year) 1916	9. Birt Co AUS:	hpiace (Sta puntry) TRIA	ate or Foreign
	/land		10a. State 10b. County		10c. City,	, Town or Lo	cation							10d. Insid	e City Limits
	Man	ţō	MARYLAND MONTGOME	RY	SIL	VER SPR	RING							10	Yes 2X No
:	n with the	Funeral Director	10e. Street and Number 33330 NORTH LEISURE	WORLD BLVD	#401		10f. Zip		906				en of What Co		MERICA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If feel 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinar must be notified at ODGs.	by Funera	11. Marital Status  1 □ Never Married 2 ② Married  3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 2 X If Yes, Give	?   No	li li	Vas Deced Yes, spec		spanic Orig , Mexican, Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)		Race - Ame Black, White pecify:		٦,
21215-0036	2 hour atural		15. Decedent's E	Year or Dates	1	16a. Deced	ent's Usua	l Occupa	tion					Industry	
715	on 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed)	F.()	(Give i	kind of wor OO NOT us	k done di	ırina most	of workir	ng	100. Kind	of Business/	industry	
21:	giene giene	Som	Liententary/Secondary (0-12)	College (1-4or 4	5+)	NUCL	EAR EN	GINEE	R			FE	DERAL GO	VERNME	NT
פ	d oth	Be	17. Father's Name (First, Middle, Last,						18. Mother	r's Name	(First, Middle,			, , , , , , , , , , , , , , , , , , , ,	
yla	Men	2	SOLOMON BURGER						GU	STI L	OEWENWIL	Γ			
Maryland	12 sh h and 7 is m rraum		19a. Informant's Name/Relationship (	Type, Print)							Route Numbe				
ب	Healt Healt Her Sher		EVA BURGER - WIFE  20a. Method of Disposition		20b. Pla	3330 N ace of Dispos			E WORL	-	D #401,		R SPRING		
Baltimore,	ages intof t; = it		1   Burial 2 □ Cremation 3 □		Cel	metery, crem	atory or ot	her place	1				tion - City or		•
	artmer artmer ortant Injury		4 ☐Donation 5 ☐ Other (Specifical Service Licer		1 300	EAN MEM				1/29/	U6 ES RINALI		Y, MARYL		
B	Ped F S		Moderate	1/_							, SILVER				
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the death.	Do not ente	r the mode	of dying	such as c	ardiac or	respiratory ar	rest,	G, FID 20	Approxi	
P	hysician		Immediate Cause (Final disease or condition		ATORY FA	ATLIERE									Between nd Death
	/Medical Examiner		resulting in death)	Due to (or as											
	-xammer		Sequentially list conditions,	D		NG CANCI	ER								
-	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):									
	sicien and burial-transit	xar	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):		_							
8760,	hysicien he buria			d											
89	incate ig phys as the	ledik		. u.											
Вох	attending p	N/ue	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pre	902001				230	d. Date of deliv	very	
Records, P.O. Box 68760,	the att	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown			Other (spe						Month	Day	Year
٦.	igned by the a	by Ph	Part II. Other significant conditions o	ontributing to death t	out not result	ing in the un	derlying ca	use giver	in Part I.		23e. Did to	bacco use	contribute to	the cause	of death?
DIVISION Of Vital Records,	been sig should b										10Y	es 2 □ 1	No 3∏Pro	bably 4	<b>J</b> Unknown
ecc ecc	as be	Completed									24a. Was a	n a	24b. Were aut	opsy findin	gs available
<u>د</u> ۾		Con									autops perform	med?	death?		f cause of
of Vita	this certificate	Be	25. Was case referred to medical examiner?		-					of Death	Check only or				
0	this idi	5	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital:		R/Outpatient			4 🗀 Nurs		e 5 🗆 Reside			fy)	
ב ס	h. After funer	盲	1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	8b. Time of Injury	M 28	c. Injury a	ıt əs 2∐Nı		3d. Describe h	ow injury o	ccurred		
VISION	after death I Director: d in by the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	ury - At hom	e, farm, stre					3f. Location (Si	reet and N	lumber or Rur	al Route N	umhor
בֿ בֿ	s afte	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)		,,				City or Town	n, State)		u, , , , , , , , , , , , , , , , , , ,	amber,
Hosoi	within 24 hours at To the Funeral D completely filled in	edicai	29 a. Certifier (Check only one)	ysician: To the best liner: On the basis of and manner st	r examinatio	edge, death n and/or inve	occurred at estigation, i	t the time n my opir	, date and lion, death	place, ar	nd due to the ca	ause(s) an ate and pla	d manner as s ace, and due t	stated. to the cause	B(S)
T of	To t	Σ	29b. Signature and title o certifier	4/			29c.	License r	number		2	9d. Date s	igned (Month,	Day, Year	)
				/K					D62885	j		11/3	600		
10			30. Name and address of person who a SONJA WYCHE, MD	completed cause of c				CDDTN	C MD	20070		1			
	Star	e	31. Date filed (Month, Day, Year)		ar's Signatur			DEKLIN	о, <sub>М</sub>	Z03T0					
	Registra		NOV 29 2	006	. h	- 0	andi s								

		1 - For State Registrar	State	of Marylan		artment of tificate of		and Me		iene g. No.	006	39795	
Discorting.		1. Decedent's Name (First, Middle	e, Last)						2. Date of Deat Month	h Day	Yeer	3. Time of Death	
Physici /Medi	_	Anne Theresa Br	iggs						Novembe:	,		5:30 P M	
Examir		4a. Fecility Name (If not institution				4b. City, Town,	or Location o	of Death		4c. C	County of Death	n	
		Holy Cross Rehab.	and Nursin	g Center 7. Age (In yrs.	last hirthday	But If Under 1 Yea	rtansvil		8. Date of Birth	Mon	tgomery	palace (State or Foreign	
Funeral Director		5. Social Security Number 579–30–2539	1 M 2  F	7. Age (in yrs. 79	Yrs.	Months Day		Min.	(Month, Day,		Cot	nplace (State or Foreign untry)	
		Usual Residence of Decedent		13				L	Dec. 24, 1	1926	washii	ngton, DC	
nyland how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits	
e Ma	cto	Maryland Prince	George's	F	lyattsvi.	lle						1 Tes X2 No	
with th	Director	10e. Street and Number				10f. Zip Code			11	0g. Citize	en of What Cou	untry?	
s 23s	eral	6711 25th Avenue	12 Was Do	cedent Ever in U.	C 12 1		0782	ain? (Sno	ofu Voe or No-		USA 4. Race - Amer	ican Indian	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Items 23a or 28a-f show aumatic event, the Maries Examire must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ② Mar  3 □ Widowed 4 □ Divorced	ried 1 Yes	Forces? 2 🙀 No Bive	ŧ	Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 ☑ N	iban, Mexican	n, Puerto R	lican, etc.)		Black, White	e, etc.	
"naturel",		15. Deceder	nt's Education		16a. Deced	ient's Usual Occ	upation				d of Business/I		
nin 72 n ne	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	(Give	kind of work don OO NOT use retii	e during most	t of workin	9			,	
d with giene ar tha	mo	12	College	(1-401 5+)	Ho	omemaker				(	Own Home		
2 should be filed within 72 he and Mental Hygiene. Is marked other than "nature raumatic event, the Musical	O O	17. Father's Name (First, Middle,	Last)				18. Mothe	r's Name	(First, Middle, A	faiden S	Sumame)		
Ment Ment arkec	2	Pietro Genovere					Ros	ina Te	naglio				
2 sho		19a. Informant's Name/Relations Francis K. Briggs			19b. Mailin	g Address (Stree	et and Numbe	er or Rural	Route Number,	City or	Town, State, Z	ip Code)	
1 and 1 and 1 ealth 1 ealth	L.	20a, Method of Disposition		20h P	6711 2	25th Avenu sition (Name of	e. Hyatt				ation - City or 1	Foun State	
To Fige		1 ⊠Burial 2 ☐ Cremation		n State	emetery, cren	natory or other p	1	Nov.		200. 200	anon only or i	iowii, otate	
it. Partition of the principle of the pr	1	<ul> <li>4 □Donation 5 □ Other (S</li> <li>21. Signature of Furteral Service</li> </ul>	· · · · · · · · · · · · · · · · · · ·	ror		coln Cemetery 2006 Brentward, aryland  22. Name and Address of Facility Francis J. Collins Funeral Home Inc.							
permit. Pages 1 and 2 should be Department of Health and Mental Importent; If item 27 is marked, any injury or other traumatic evonce.		) 9/ll-	1/3V										
		23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that	caused the deat	h. Do not ent	O Universe of dearthe mode of de	ying, such as	cardiac or	respiratory arre	ring, ist,	, MD 2090	Approximate Interval Between	
Physician		Immediate Cause (Final		1etus	Latic	Carre	n- 12-1	120.0	1_			Onset and Death	
/Medical		disease or condition resulting in death)		o (or as a conseq		Canc	e (B)	CAS					
Examiner		Sequentially list conditions	b										
p tis	Examiner	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										
and and i-tran	хап	that initiated events resulting in death) Last	c. Due to	o (or as a conseq	uence of):	of):							
be es sician buria				,	,								
flicate g phys	edical		0										
eath certificate be executed attending physician and for use as the buriat-transit	an/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		JEctopic pregnar	nov.			23	3d. Date of deliv		
deat ne attr	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of d		Other (specify)					Month	Day Year	
that the de	Physici	9 Unknown											
signed to	by	Part II. Other significant conditi	ons contributing to	death but not res	ulting in the ui	nderlying cause (	given in Part I.	,				the cause of death?	
w requir been si should	ompleted			<u> </u>									
sician: The law certificate has b irector, page 2 s	mple								24a. Was ar autops perform	v	24b. Were aut prior to c death?	topsy findings available ompletion of cause of	
ysician: The lis certificate ha	O								1 Yes 2	[⊋(No	1 🗆 Yes	22No	
siciar certif recto	o Be	25. Was case referred to medica examiner?	Hospital:	71			)thor		(Check only one		CO. (0		
Phys r this	1	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Dat	e of Injury	ER/Outpatien 28b. Time of	28c. In	iurv at		ie 5 🗆 Reside 8d. Describe ho			ify)	
Ith. TAfte	ation	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (Mo igation	nth, Day Year)	Injury		fork? ∐Yes 2 ∐1	No					
Attending Ph ordeath. ector: After th by the funeral	ertification;	3 Suicide 6 Could 4 Homicide determ	nined 286. Place	ce of Injury - At he ding, etc. (Specif	ome, farm, str	eet, factory, offic	е	21	8f. Location (Str. City or Town		Number or Rui	ral Route Number,	
rs afte	O			100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	72,		4					
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeret Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifyi (Check only one) 1 Medical	ng Physician: To the Examiner: On the and ma	he best of my kno basis of examina inner stated.	owledge, death	occurred at the vestigation, in my	time, date and opinion, deat	d place, ar th occurre	nd due to the ca d at the time, da	use(s) a ite and p	and manner as place, and due	stated. to the cause(s)	
To ti To ti Comp	Ž	29b. Signature and title of certifie	er in				nse number		29		signed (Month	, Day, Year)	
		1	1.1			1000	5456	6		11/2	16/06		
7		30. Name and address of person					4	)	Cher		ESUSCES.		
		31 Date filed (Month Day Vac	laville 12	Pagistrar's Signs	15 - JOK	pano	ed Stei	423	O TOW	90/	UMD	21.2 86-	
St Regist	ate rar	SUNCTION POLY 31. Date filed (Month, Day, Year XVV 2	9 2006	Sustain a Signa	is A	reales				+-			

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Kos It HENIN ·111AM November 26 201 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July, 29, 1938 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1**X** M 2□ F Pennsylvania 68 165-32-4524 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Gaithersburg Maryland Montgomery 1 AYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20877 United States 102 Tulip Drive Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Yes 2 No 1956— If Yes, Give Year or Dates: 1962 1 ☐ Never Married 2 Married Specify: WHITE 1 ☐ Yes 2X No Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Service Station Attendant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Henry Bosley Lucy Ayres ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty D. Bosley (Wife) 102 Tulip Drive Gaithersburg, MD. 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Mem. Park Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2006 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Devol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD. 20877 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Polineware **Physician** + aus /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown þ Be Completed Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

r 28a-f show notified at

an "natural", or Items 23a or Medical Examiner must be

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Me

20

Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Dianetes	Me/1. tos	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
Croway A. H	en Discare	24a. Was an autopsy performed?  1 ☐ Yes 2 ☐ No  24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 → npatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Hom	e 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 汪\atural 5 □ Pending 2 □ Accident investigatio	(Month, Day Year) Injury Work?	3d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined		Bf. Location (Street and Number or Rural Route Number, City or Town, State)
20a Cartifier 1 Cartifying P	hysician. To the best of my knowledge, death occurred at the time, date and place, a	nd due to the cause(s) and manner as stated

29b. Signature and title of certifier Δ

29c. License number 53317

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) November 27 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Read #213 Gaitherbung 1622 & frederick Boll 135/16 A 31. Date filed (Month, Day, Year) 32. Reistrar's Signature

State Registrar

Medical

NOV 29

			State Registrar State Registrar	te of Maryland / De /06,DPS,McCo (	epartment of F Certificate of	lealth and I Death	Mental Hygie		39797
			Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		Queenie Annie Ba	rmer			Nov 2	0 2006	7:00 P M
	Examin		4a. Facility Name (If not institution, give street a	nd number)	4b. City, Town, o	r Location of Death		4c. County of Death	
			Southern Maryland Hosp	oital	Clintor			Prince Geo	
ы	Funeral		5. Social Security Number 6. Sex 1 M 2 €	7. Age (In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear 1941 9. Birth	place (State or Foreign
	Director		239-66-1216 Usual Residence of Decedent	65 "			Jan 23,	<del>2941</del>   Gary	sburg N C
	yland		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	a-f s	Funeral Director	MD Prince Georg	es Brand	ywine, MD				1XXYes 2 □ No
	or 28	ojre.	10e. Street and Number		10f. Zip Code		10g.	. Citizen of What Cou	ntry?
	23a	la	11914 Elmwood Drive		20613			USA	
	er de	nue	Am	s Decedent Ever in U.S. led Forces?	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	ispanic Origin? (Si an, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - Ameri Black, White,	
36	rs aft	by F		Yes 2 No es, Give ir or Dates:	1 ☐ Yes 2(X)No	Specify:		Specify: B1	ack
Ö	within 72 hours after death with the Maryland ene. than "naturel", or Items 23s or 28s-f show he Medical Examiliar minal be notified at	ed	15. Decedent's Education	16a. D	ecedent's Usual Occup		168	b. Kind of Business/In	
75	nin 72 In "In	pie	(Specify only highest grade comp.  Elementary/Secondary (0-12) Coll	(eted) ((	Give kind of work done if a DO NOT use retired	during most of wor d)	king		,
21	d with	Completed		ogo (1 401 51)	Nurse		Pr	ivate Dut	У
p	al Hy al Hy d oth	Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, Mai	iden Sumame)	
yla	Ment Ment arked atic a	ဂ္ဂ	Raleigh Crowell			<u>`</u>	Atkinson		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23s or 28s-1 show ery injury or other traumatic avent, the Medical Examinat must be notified at once.		David Barmer (Husba		Mailing Address (Street 914 Elmwood	and Number or Ru I Dr. Bra	ndywine, f	ity or Town, State, Zip Md	Code)
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova	cometen	isposition (Name of crematory or other place	(e)		c. Location - City or To	
Ĕ	Pag ment ant: I		4 □Donation 5 □ Other (Specify)	Harmon	y Memorial	Dec	2, 2006 La	andover, M	ט
Balt	permit. Depart Import eny Inj once.		21. Signature of Funeral Service Licensee  Terry A Austin	Udhoto				ter Funera gton D C 2	
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do no					Approximate Interval Between
V	Physician		Immediate Cause (Final		obstruct	Les P.	1 2 2 2	N. D. C.	Onset and Death
	/Medical		7 11150	14					
	Examiner		Sequentially list conditions, b	54H 5					
	p #s	Examiner	d any, reading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a consequence of)					
	and and I-tran	хап	that initiated events c.	ue to (or as a consequence of)					
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687	tificate ng phys as the	edic	d.						
Box	eath certifi. ettending I for use as	Ž		es, outcome of pregnancy				23d. Date of delive	ery
Ď.	death e ette d for	Physician/Me	in the past 12 months?	Live birth 2 Tetal death Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
P.0.	oy th	hys	9 □Unknown 9⊔	Unknown					
S,	iw requires thet the s been signed by th should be detache	Ą	Part II. Other significant conditions contributing	g to death but not resulting in the	he underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to t	ne cause of death?
D.	equirision si	Completed by	Congestive +	1691 151	1426		1 🗆 Yes	2 □ No 3 □ Prot	pably 4 Drűnknown
ပ္ပ	> 11 0	bie	CORONARY	AUTERY	DI SEE ST	c	24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
<u> </u>	The law sete has b page 2 s	5		, ,			performed 1 ☐ Yes 2 ☐	d? death?	2 1 No
/ita	Physician: The lav this certificate has al director, page 2	Be	25. Was case referred to medical examiner?				th (Check only one)		
<b>d</b>	Physician: this certific ral director,	ဥ	1 Yes 2 No Hospital	1 @rinpatient 2 LI ER/Outp	atient 3 DOA Oth	4   Nursing n		e 6 □Other (Specif	y)
UC	ting f	o		Date of Injury (Month, Day Year) 28b. Tin	ıry Wor		28d. Describe how i	injury occurred	
<u>s</u>	death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be	Place of Injury - At home, farm		Yes 2 □ No	28f Location (Street	t and Number or Rura	al Route Number
Division of Vital Records,	after Dirac	Certification:	4 Homicide determined	building, etc. (Specify)	i, street, ractory, office		City or Town, S	State)	in riodie radiiber,
	To the Hospital or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di		(Check only 2 Medical Examiner: On	To the best of my knowledge, of the basis of examination and/	death occurred at the tire or investigation, in my o	ne, date and place pinion, death occu	and due to the caus	e(s) and manner as s	tated.
	thin 2 tha 1 mplet	Medical	one) and 29b. Signature and title of certifier	d manner stated.	29c. Licens				
1	S T W S		200. Signature and title or continer		25C. LICONS	1988	C.	Date signed (Month,	
•	4	}	20. Namo and address of secretary	d course of death // co	no Brief)	1 0 0		20-21-	06
	/		January Botello	cause of death (Item 23a) (1)	ype, mint)	A. A.	55-	D 6 20	20 2 2
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	3041718	KN 110	and the	2 2 2 6	0 3 2
	Registr		NOV 29 2006	Kowe !!	Aparte				

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			For State Registrar	i	State of N	naryiand		irtment of F tificate of	lealth and N <i>Death</i>	nental Hy	giene Reg. No	0000	3	0708
ľ			Decedent's Name (First,	, Middle, Last)						2. Date of De				me of Death
	Physicia /Medio		Sonia				1:	Bricker		Decemb	45	0 2006		50 AM
	Examin	er	4a. Facility Name (If not ins	Hapki'v	1.3	spita)		Baltiv	r Location of Death	ity	- 40	. County of Deat Balti		2
	Funeral		5. Social Security Number	6. Sex		Age (In yrs. las	t birthday). Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th ay, Year,	9. Birti		tate or Foreign
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	aryland show d at	_	10a. State 10b. (	County		10c. City,	Town or Lo							de City Limits
	the Ma 28a-f	Director	PA 10e. Street and Number	York			Dot	7er			10g. Ci	tizen of What Co		
	72 hours after death with the Maryland Inatural", or Items 23a or 28a-f show dical Examiner must be notified at		3364 Colby	y Lane					315		US	SA	·	
	er deat	Funeral	11. Marital Status		2. Was Deceder Armed Forces	s?	13. \	Was Decedent of H f Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White		ın,
036	hours after tural", or Ite al Examine	by	1 □ Never Married 2		1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	:: ₹₩0		I□Yes 2 <b>X</b> No	Specify:			Specify: Wh	ite	
5-0036	72 hol natura dical E	Completed	15. Do (Specify only	ecedent's Educa y highest grade	ation co <i>mpleted)</i>		16a. Deced	dent's Usual Occup	oation during most of work d)	king	16b. k	Kind of Business/	ndustry	
121	d within 72 ho giene. r than "natu the Medical	dmo	Elementary/Secondary (	(0-12)	College (1-4o	r 5+)		ervisor	a)		U.5	S. Gove	rnme	ent
andz	be filed ntal Hygi od other event, t	Be C	17. Father's Name (First, I	Middle, Last)					18. Mother's Nam	e (First, Middle	, Maidei	n Surname)		
	should to	2	Samuel H.  19a. Informant's Name/Re				10h Mailin	a Address /Street	Ruth S			or Town State 7	Zin Code)	
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ore,	ges 1 and t of Health If item 27 or other tr		20a. Method of Disposition	1		20b. Pla	ce of Dispo	sition (Name of natory or other pla	i	pate per 15.		ocation - City or		
altimore,	permit. Pages Department of i Important: If it any injury or o		4 □ Donation 5 □ C	Other (Specify)		Çeme	eters	7	: 200	6	Sh:	ippensb	urg	, PA
a R	Depa impo any i		22. Name and Address of Facility J. J. Hartenston 1424 Second ST, New Freedom, P.											
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	law requires that the as been signed by th 2 should be detache	ρ	Part II. Other significant	conditions cont	ributing to death	but not result	ing in the ui	nderlying cause giv	en in Part I.		Yes 2	use contribute to 2 ☐ No 3 ☐ Pr		e of death?
ecords,	w requir s been si should	letec								24a. Was		24b. Were au	topsy find	lings available
Ž H	The ate h page	Completed								auto perfi 1∐ Yes	opsy ormed? 2 2 N	death?		n of cause of
Vital H	lclan: certific ector,	Be	25. Was case referred to examiner?		ospital:			t 3 DOA Oth	26. Place of Dea					
	g Phys er this eral dir	n: To	1 Nes 2 No 27. Manner of Death		28a. Date of Ir	njury 2	28b. Time o	I SU DOA	4 ⊔ Nursing H	ome 5 ☐ Res 28d. Describe		6 □Other (Specury occurred	cify)	
Sion	Attending F death. ctor: After y the funera	atio	2 Accident	Pending investigation		Day Year)	Injury	M 1	Yes 2□No					
DIVISION OF	or Attracter de Directer in by t	Certification:	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of i building,	injury - At hom etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location ( City or To		nd Number or Ru e)	ıral Route	Number,
_	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certification filled in by the funeral director, tely filled.								me, date and place opinion, death occu					(a)
	the the the	Medical	one) 29b. Signature and title of	Laertifier	and manner		on and or in	29c. Licens		Trought the time		ate signed (Monta		
)	Vitt		1/1/4		M.D.				es-00		De	cember		
	30		Errc J He		,00 No	orth b	volle	Street	, Baltin	nore,	Mai	yland	21	287
	Sta Registi		31. Date filed (Month, Day			strar's Signatu	ire do	and I		(		1		
					C.		-							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DECEMBER 7 2006 1:15 p M JACQUELINE BRISCOE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Chester River Manor Chestertown Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 24, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1930 Maryland 1 □ M 2 🖫 F 76 220-28-1810 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Examinat must be notified at 1 ☐ Yes 2X No Director MD Kent Galena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31785 Olivet Circle 21635 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 3 2 should be filed within h and Mental Hygiene.7 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker Food Processor 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Harris it. Pages 1 and 2 should be introduted to Health and Mentant and Item 27 is marked Henrietta Benson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Galena, MD. 21635 (husband) P.O. Box 184 George Briscoe injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 12/14/06 permit. Pag Department Important: I Olivet Cemetery Galena, MD. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Meansee Calena Funeral Home of Stephen M00510 23 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myo CARDINE

Due to (or as a consequence of): Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to for as a consequence of). Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 Yes 2 No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 ☐ Yes 2 ☐ No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funeral C 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29d. Date signed (Month, Dey, Year) 29b. Signature D0060301 30. Name and address of person who completed cause e of death (Item 23a) (Type, Print) Michael E. Peimer, M.D. 122 Speer Rd. Chestertown, MD. 32. Segistrar's Signature 31. Date filed (Month, Day, Year) 1 4 2006 Registrar

### 06-09199

Ronald Dale Becker

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar		tificate of Deat		, 0	eg. No. 200	6 3980				
Medic	Physicia al Exami		Decedent's Name (First, Middle, Last)				2. Date of Dea Month Decembe		3. Time of Death				
neuro.	ai Laiiii	IIIGI	Ronald Dale Becker  4a. Facility Name (if not institution, give street and number	)	4b. City	Town, or Location		4c. County of Death					
			Upper Chesapeake Medical Center	•	Bel A			Harford	·				
	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. la			er 24Hrs. 8 Date of Bi	\	thplace (State or				
	Director		214-72-6138 1x M 2 F  Usual Residence of Decedent	49	Yrs. Month	ns Days Hours	Min. Apr.	23, 1957 Co	untry)Maryland				
	v any		10a. State 10b. County	10c. City,	Town or Location				10d Inside City Limits				
	Maryland 28a-f show d at once.	ō	Maryland Harford	Jar	rettsville				1 Yes 2 X No				
	Mary r 28a- ed at	Director	10e. Street and Number		10f. Zip		1	0g. Citizen of What Cour	ntry?				
	ith the Maryland 23a or 28a-f sho notified at once		2300 Northcliff Drive  11. Marital Status 12. Was Deceden	• Evenie III		21084		USA					
	eath w items ust be	Funeral	1 Never Married 2 Married Armed Forces	?			gin? ( Specify Yes or No Puerto Rican, etc.)	White, etc.	ican Indian, Black,				
	ifter de Il", or ner m		3 Widowed 4 Divorced If Yes, Give Year or Dates:	Ŋ No	1 Yes 2	X No specify		Specify: Wh	nite				
	nours a	ed by	15. Decedent's Education (Specify only highest grade co	npleted)	16a Decedent's Usual during most of wor			16b. Kind of Business/I	ndustry				
36	and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f she trammatic event, the Medical Examiner must be notified at once	ompleted	Elementary/Secondary (0-12) College (1-4 or 12	5+)	Home Ins	_	ase remed)	Real Est	ate				
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215	be fill ental F irked	Be	Albert Norman Becker				ginia Lee 1						
	permit. Pages   and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tl injury or other traumatic event: the Meg	욘	19a. Informant's Name/Relationship (Type, Print )  Joy Becker/ Wife					nber, City or Town, State					
MD.	and 2 ealth a em 27		20a. Method of Disposition	20b. F	Place of Disposition (Nar		Date Date	20c. Location - City or					
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Itin	nit. Pa artmer ortan ry or		4 Johnston 5 Oher Specify.  21. Signature of Fundamental Specify.	111		- 1		(	HYLAIU				
B	Dep Imp		MCComas Funeral Home, P. A.										
	hysician		23a Fart I. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	Medical xaminer												
			or condition resulting in death)  Due to (or as a cons	equence of	). disease								
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760,	ficate g phys	/Me	IF FEMALE: 23c. If yes, outco		nancy	- 🖂	- Arognosou	23d. Date of delivery					
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P.O.		by P	Part II. Other significant conditions contributing to deal	h but not re	sulting in the underlying	cause given in Pa		bbacco use contribute to to 2 No 3 Prob					
	equires t						24a Was		topsy findings available				
of Vital Records,	law ro has b	Completed				<del></del>		prior to commed? death?	ompletion of cause of				
Re	cian: The l certificate b ector, page		25. Was case referred to medical			26.Place of Death (	Check only one)	2 No 1 Ye	s 2 No				
/ita	ysician: his certif director,	o Be	examiner?	ent 2		OA Other		Residence 6 V Other	Scene				
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only one) 2 Medical Examiner: On the basis of examiner										
	To To	Med	29b. Signature and title of certifier	e .		. License number	<del></del>	29d Date signed (Mon					
			Mling Brassell 11	5		O.C.M.E.		December 4, 200	6				
			30. Name and address of person who completed cause of	death (Item	23a)			1					
			Melissa Brassell, MD Assistant Medica		er 111 Penn Str	reet, Baltimore	e, MD 21201						
	St Regist		31. Date filed (Mont) Par Year) 3 2006 32. Registra	r's Signatur	o post								

State of Maryland / Department of Health and Mental Hygiene- U Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 4:30 pm M 2ĺ, 2006 November Irma Christian /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Bethesda Health and Rehabilitation Ctr. Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2KXF Days Yrs 1929 Unknown May 15, Director 341-24-2777 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City. Town or Location r 28e-f ahow 1 Yes 2 No Directo Bethesda Maryland | Mongomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 20814 United States 5721 Grosvenor Lane filed within 72 hours after death Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 Yes 2 No Specify: Specify: δ 3 ☐ Widowed 4 ☐ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Ine Mis Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown Unknown other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill Deperment of Heelth and Mental Himportant: If Itam 27 is marked oth any injury or other traumatic avantance. Be Unknown 2 Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 100 E. Franklin Avenue; Silver Spring, MD 20901 Paula Martin / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 11/29/2006 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 0 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 21. Signature of Funeral Service Licenses 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate se (Final disease or condition resulting in death) Metastatic Breast Cancer **Physician** /Medical Due to (or as a consequence of): Examiner Liver metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cerebrovascular accident Due to (or as a consequence of): Box 68760. Completed by Physician/Medical Aortic stenosis as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year be detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 200No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been signated bage 2 should b Hypertension 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after deeth.
To the Funeral Diractor: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 XNo ဥ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Tes 2 No 2 Accident 3 🖺 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ada Nov. 27, 2006 D53691 ss of person who completed cause of death (Item 23a) (Type, Print) 6320 Democracy Blvd. Bethesda, Maryland 20817 Ajay Reddy, M.D.

State Registrar 31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

32. Apgistrar's Signature

			For State Registrar	State of Maryla		artment of F		Mental Hy	2	006	39802
			Decedent's Name (First, Middle, Last	)		imouto or	Doutin	2. Date of De	Reg. N	000	3. Time of Death
	Physic		David Thomas	Crawford	ı			Month	30	2006	10:25 P <sup>M</sup>
	/Medi Examir		4a. Facility Name (If not institution, give		L	4b. City. Town. o	r Location of Dea	Nov.		ounty of Death	10:23 P
6	LXdilli	ici	Garrett County M		tal	0ak1ar				arrett	
	Funeral		5. Social Security Number 6. Se			If Under 1 Year	If Under 24 Hrs		th		place (State or Foreign
	Director		300-28-8380	DM 2□F 74	Yrs.	Months Days	Hours Min.	Month, Da	y, Year) 193	Сош	Virginia
	P .		Usual Residence of Decedent					1108.	, 175.		72282120
	show	_	10a. State 10b. County	10c. C	ity, Town or Lo	ocation				1	0d. Inside City Limits
	Ba-f	5	MD Garrett	C	akland						1 XYes 2 □ No
	ours after death with the Marylan's!', or items 23a or 28a-f show	Director	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cour	ntry?
	ath w		109 N. Second Str	eet		21550			Uni	ted Sta	tes
	er de	Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14	Race - Amend Black, White,	
36	s afte	by Fe	1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give		1 Yes 2 No	Specify:	, ,		pecify:	oto.
8	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Examinar must be notified at	D D	3 Widowed 4 Divorced	Year or Dates:						Whi	
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d 2	Hygin Hygin ther		17. Father's Name (First, Middle, Last)	5+	Sur	geon & Me		. <b>r.</b> me ( <i>First, Middl</i> e,		spital	
an	d be antal	o Be		Crawford							
7	d 2 should th and Men 7 is marke traumatic	7	David William  19a. Informant's Name/Relationship (Ty			ng Address (Street	Gladys			chell	0.11
Maryland	2 2 2 2 2		Mary Ann Crawford								Code)
	He He		20a. Method of Disposition			N. Secon	a Street	Date		tion - City or To	uun Stata
Baltimore,	0 - F		1 ☐ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	cemetery, crer	natory or other place	1			-	
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Ba	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service Licens	90	22	. Name and Addre	υu	rdock-Du			
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87	phys the	dicai									
9 x	eath certifii attending p	by Physician/Med	IF FEMALE:	20 If you suitoome of cross							
Вох	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	ıl déath 3 [	Ectopic pregnancy			230	<ol> <li>Date of delive Month</li> </ol>	ry Day Year
o.	the de	yslc	1 Yes 2 No	4□Pregnant at time of d 9□Unknown	leath 5∟	Other (specify)				TOTAL T	Duy Tour
<u>α</u>	that the de led by the a detached f	P.	Part II. Other significant conditions con	tributing to death but not res	culting in the ur	idorhina couca auc	an in Port I	220 Did to	bass use		
Vital Records,	98 PS	by	F. 1-54			Compiling Cause give	en in Parti,			_	e cause of death?
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=	cate pag	S						perfor	med?	death? 1 ☐ Yes	21 NO
ij	Physicien: The la rthis certificate has and director, page 2	Be	25. Was case referred to medical examiner?				26. Place of Dea	th Check only or	ne)		
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2	ing F After unera	on;	27. Manner of Death 1 ☑ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe h	ow injury o	ccurred	
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Division of	or At iter d irect n by	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and N	lumber or Aural	Route Number,
	urs e										
	To the Hospitel or Attending Ph within 24 hours eiter death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Phys	sician: To the best of my knower: On the basis of examina	wledge, death	occurred at the time	e, date and place	, and due to the o	ause(s) an	d manner as sta	ated.
	To the within 2 To the complet	Med		and manner stated.							
	5 × 5 0	_	29b. Signature and title of perfeter			29c. License	number	/ //	29d. Date s	igned (Month, L	Day, Year)
7			1870	all a	the	102	146	. 4	11/	30/0	6
			30. Name and address of person who co	//						ı	
			Dr. Sotiere Savo			Fourth	Street,	Oakland,	MD 2	1550	
	Sta Registra	_		32. Registrar's Signa	Me A	and D					
		56	130 the 13	See The Control of th	AS ASSESSED	Bullion Links Andrews					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra#5 per FH/wichd/12-11-06/dls Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Stanley Η. Chatham Sr. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner REGIONA Niamico SAUSBUNG If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Yea 3-5-1918 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 ☐ F 88 Yrs Director Maryländ Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show items 23a or 28a-f showner must be notified at 1 ☐ Yes 2X No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1616 Lavale Court 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian 'natural', or item dical Examiner Black White etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White \$ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Telephone Foreman Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic events injury or other traumatic events. Carl Chatham ပ္ Eva Mariner 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley H. Chatham, Jr. - son 1616 Lavale Court, Salisbury, MD 21804 Baltimoré, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 □Removal from State Wicomico Memorial Park 12-2-06 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licenses 705 E. Main Street, Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1∐ Yes 2 4 No 2 🗆 No 1 TYes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No Certification: To 1 Tes 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Director: within 24 hours after To the Funeral Dire Hospital

Joh C

State Registrar

Medical

29a, Certifier

29b. Signature and title of certifie

and manner stated.

of person who completed cause of death (Item 23a) (Type

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

11-29-2004

			For State Registrar	, , , ,	S	tate of	f Mary	land / De	partmei <i>ertifica</i>				lental Hy	/giene	2 U U	6	39804	
	Physicia	an	Decedent's Name										2. Date of D Month	Da		Year	3. Time of Death	
	/Medic	ai	ANTHON 4a. Facility Name (//				NTINO	SR	4b. City	Town or	r Location o	of Death	NOUS		County of	Death	0650	_
	Examin	er	Peninsula					Cente			1136				Wice		Cò	
	Funeral		5. Social Security N	umber 9	6. Sex	2 F	7. Age (In	yrs. last birthe	(ay) If Under	r 1 Year	If Under Hours		8. Date of Bi (Month, D	irth ay, Year,	)	9. Birthp Coun	alace (State or Foreign	_
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	<u> </u>	Fun	11. Marital Status 1 ☐ Never Marri	ied 2. ☑ Marri	ed	Armed For	rces? 2 ☐ No	1772					ecify Yes or N Rican, etc.)	0		, White,	etc.	
036	ral, or	by	3 🗆 Widowed	4 1		If Yes, Giv Year or Da	ates.	to 1945	1 🗌 Yes	No.	Specify:				Specify:	Wi	nite	
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5 10	nt of h		1 ⊠ Burial 2	Cremation		oval from S		Ob. Place of D cemetery, Garden			(e)	.2-01			timor	•		
Anthony Baltimore,	permit Pages Department of Important: If I any Injury or once.		4 □ Donation  21. Signature of Fu	//		100.								Daz	CHIOI	C, I		
Ba Ba	Departr Departr Import any in		N/A	Win C	anst	on			Crans				ome rd, DE	100	72			
	TAIL S		23a. P v11. Enter to sv ck, or hea	he disease, or rt failure. List	complicati	ions that ca	aused the	death. Do no	enter the mo	de of dyin	g, such as	cardiac	or respiratory	arrest,	4 113		Approximate Interval Between	
	Physician		Immediate Cause disease or condition	(Final			20	The	cole	n	0		art	_			Onset and Death	
	/Medical Examiner		resulting in death)			Due to (	or as a co	nsequence of)	in I		N	ens	suc	vi.	*	-	2 los	
		-a	Sequentially list co	nditions,	b	Due to (	or as a coi	nsequence of)			/'-					-		
	uted d ansit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events	rlying injury	<b>S</b> c. =													
oʻ	ate be executed nysicien and he burial-transit	Exa	resulting in death)	Last		Due to (	or as a co	nsequence of)										
	ate be physici the bu	lcal			d											_		_
x 68	ertifica ding ph	/Mec	IF FEMALE:		230	If yes out	come of pr	reananay										-
Вох	eath certific attending pl	Physiclan/Med	23b. Was deceden in the past 12	months?	200.	1 Live b		Fetal death	3 ☐Ectopic   5 ☐ Other (s		,			- 1	23d. Date Mont		Day Year	
o.	by the detached	hysi	1 □ Yes 2 [ 9 □ Unknown			9□ Unkno			0									
Division of Vital Records, P.O	Attending Physician: The law requires that the death certifica r death.  coer: After this certificete has been signed by the attending ph ector: After this certificete has been signed by the funeral director, page 2 should be detached for use as the	by P	Part II. Other signif	ficant condition	ns contrib	outing to de	ath but no	ot resulting in t	e underlying	cause givi	en in Part I		23e. Did	tobacco	use contrib	oute to th	ne cause of death?	
ğ	w require been sig should b	ted t											1 🗆	Yes 2	□ No 3	3 🗌 Prob	ably 4 Honknown	
ပိ	Biawr has be	Completed											24a. Was	vago	pri	ior to cor	psy findings available impletion of cause of	
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V Its	ysician: is certific director.	o Be	25. Was case refer examiner?		Hosp	pital:	/	2 C C C C C C C C C C C C C C C C C C C		Oth	AP.		Check only		• Fla::			
ð	Phys ar this aral di	-	1 ☐ Yes 2 ☑ 27. Manner of Deat		12		npatient of Injury th, Day Yea	2 ER/Outp		28c. Injun Worl	4 🗆 N		me 5 ☐ Res 28d. Describe			1-7	V)	-
ion	death. ctor: After y the funer	atlo	Natural 2 ☐ Accident	5 Pendin investig	ation	(MONI	n, Day rea	ar) Inju	M M		k? Yes 2 ☐	No						
ĕ	i or Attend efter death Director: , d in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 🗌 Could i determ		28e. Place buildir	of Injury - ng, etc. (S	At home, farm	, street, facto	ry, office			28f. Location City or To	(Street al	nd Number e)	r or Rura	l Route Number,	
۵	spital or At ours efter overal Direc filled in by	Ce	20- 0-45	1990				1 1.1.										
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by 1	edical	29a. Certifier (Check only one)	Certifyin 2 Medical	g Physici Examiner:	: On the ba	asis of exa ner stated.	y knowledge, o imination and/	or investigation	at the time, in my of	ne, date an pinion, dea	id place, ith occurr	and due to the ed at the time	e cause(s , date an	) and man d place, ar	ner as st nd due to	ated. the cause(s)	
	To the Within To the sompli	Me	29b. Signature and	title of certifier	M	5	11.	)	29	c. License	e number			29d. Da	ite signed	(Month,	Day, Year)	-
	102		<b>)</b> (	M	16	M	1	la,	1)		22	5	209	7	1	1/2	716	
_	00,0		30. Name and a	s of person	who comp	leted caus	e of death	(Item 23a) (T	rpe, Print)				-				n i nin <del>Maryan</del>	
	1./.		31. Date filed (Mon	oth Day Year	CE	2 A	mistrar's S		S. Di	visi	on St	., S	alisbu	ry, I	4D 21	804		_
	Sta Registr		St. Date med (MOI	NOV 2	9 200		Calus	K	Spark									

			For State Registrar	State of N	1arylan		artmen rtificat			ind M		giene Reg. No.2 ()	06	39805
H	Physicia		Decedent's Name (First, Middle,		_	_					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	ai	Virginia 4a. Facility Name (If not institution,	I.		ook	4h City	Town or	Location of		Novemb		2006 ty of Death	9:55 P M
	Examin	er	Prince George's	-	')			erly		Death			e Geo	rge's
	Funeral			6. Sex 7. /	Age (In yrs.	last birthday)	If Under	1 Year	If Under 2		8. Date of Birt (Month, Da)	h		lace (State or Foreign
в	Director		577-52-7746	1 □ M 2 🕅 F	70	Yrs.	Months	Days	Hours	Min.	3/24/19	936		h Carolina
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	Od. Inside City Limits
	Maryli f eho	ō	DC			hingto								X Yes 2 □ No
	3e or 28e	Il Director	10e. Street and Number 2600 22nd Stre	eet NE			10f. Zip	Code 20018				10g. Citizen o Unite	f What Coun	try? tes
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 ie marked other then "natural; or Iteme 23e or 28e-f show any injury or other traumatic event. In Medical Examinat must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Deceder Armed Forces at 1 Yes 2 N If Yes, Give Year or Dates	? ] No		Was Dece If Yes, spe		spanic Orig n, Mexican, Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	ВІ	ace - Americ ack, White,	etc.
Ö	hours turai'	ed b	31√ Widowed 4 □ Divorced  15. Decedent'		i: 	16a, Dece	dent's 1 Isu	al Occupa	tion		1	16b. Kind of	Business/Inc	dustry
15	n na	Completed	(Specify only highest	grade completed)	· F · \	(Give	kind of wo	rk done d se retired,	uring most	of workir	ng	100.11110	0401110041110	
212	d with giene	E	Elementary/Secondary (0-12)	College (1-4o	1 3+)	Homem	aker					Domest	ic	
g	al Hy d oth	Bec	17. Father's Name (First, Middle, L								(First, Middle,	Maiden Suma	ame)	
yla	ould b Ment warked	To Be	Claude Gilber			Ţ			Thelm		larsh			
, Mar	and 2 sh salth and n 27 ie m		19a. Informant's Name/Relationsh Cheryl Frye (	daughter )	ų.	341	Dawk	ins		et A	Berdeeı Berdeeı	n, NC 2	8315	
Baltimore, Maryland 21215-0036	Pages 1 nent of Haint: If iter ury or oth		20a. Method of Disposition 1 ∑Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		_   0	Place of Dispo emetery, crei t Linc	natory or o	ther place			4/2006	20c. Location Brent	-	
Balti	permit. Departnimports any integrates		21. Signature of Funeral Service	icensee							Lincol oad Br			
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition	only one cause on each	ed the death line. tic S		er the mod	de of dying	, such as o	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	is a conseq is	uence of):								
	uted d ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to lor a	is a cons	uence of								
8760,	icate be executed physicien and s the burial-transit	al Exa	resulting in death) Last	Due to (or a	is a conseq	uence of):								
687	ficate physis the	edlc		d										
Вох	e death certificate be executed the attending physicien and hed for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	Ideath 3[	Ectopic p Other (s					1	ate of delive Month	ry Day Year
P.O.	that the de led by the a detached f		Part II. Other significant condition	ns contributing to death	but not res	ulting in the u	nderlying	ause give	n in Part I.		23e. Did to	obacco use co	ntribute to th	e cause of death?
rds	law requires that the as been signed by th 2 should be detache	ed by									101	′es 2⊠No	3 ☐ Prob	ably 4 Unknown
of Vital Records,	The law re ate has be page 2 sho	Completed					<u>-</u>						prior to cor death?	osy findings available inpletion of cause of 2 No
/ita	ician: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital				0		of Death	(Check only o	ne)		
	To the Hospital or Attending Physicien: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	on: To	1 ☐ Yes 2 ₹ No  27. Manner of Death 1 ② Natural 5 ☐ Pending	Hospital: 1 Inpa  28a. Date of Ir (Month, L		ER/Outpatier 28b. Time o Injury	f	28c. Injury Work	at ?	2	ne 5 Resident			r)
Division	or Attend ifter death Director: /	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of	njury - At ho etc. (Specif	ome, farm, sti	M reet, factor		'es 2 □ N		8f. Location (S City or Tox		nber or Rura	I Route Number,
	Hospital	edical Ce	29a. Certifier 1 XCertifying (Check only 2 Medical E	g Physician: To the be examiner: On the basis	st of my kno	wledge, deat	h occurred	at the tim	e, date and	d place, a	nd due to the	cause(s) and r	manner as st	ated.
	To the h within 24 To the R complete	Med	one) 29b. Signature and title of certifier	and manner	stated.			c. License				29d. Date sign		
	2 2 2 8		1	UU	V.				1405				2/2006	. · ··/
K	- (6)		30. Name and address of person values Norman Allen	who completed cause o				rlv.	MD 2	20785				
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 8 200		strar's Signa	iture port	V	,,						

			1 - For State Registrar	State of Ma	-	partmen ertificat			nd Me	, ,	jiene	006	398	306
			Decedent's Name (First, Middle, Last)		-					2. Date of Dea	th		3. Time of	f Death
	Physici		John	Cooksey					N	ovember	21.	2006	6:00	ОРМ
je.	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or	Location of				ounty of Death		
			Joseph Richie Hosp	ice		Ba1t	imor	e Cit	У					
	Funeral		5. Social Security Number 6. Sex		e (In yrs. last birthd	ay) If Under Months	1 Year Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Birth	Year)	9. Birth	nplace (State ountry)	or Foreign
	Director			M 2□F 9	3 Yrs	. IVIORAIS	Days	710013		1/13/19	13		ntwood,	, MD
	p P		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location							10d. Inside C	ib. Limits
	eho	ត	MD Calvert		Owings	2004,011								2 No
	the A	ect	10e. Street and Number			10f. Zip	Code				On Citizen	n of What Cou		
	with a d	ᅙ	1611 Roam Court				736					ed Sta	,	
	heath	Funeral Director		12. Was Decedent B	ver in U.S.			nanic Origin	n? (Spec	cify Yes or No-		. Race - Amer		
<b>'</b> O	riter	필	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ N		If Yes, spec	orty Cuban	i, Mexican, I	Puerto P	lican, etc.)		Black, White	, etc.	
ဗ္ဗ	er's a	<u>م</u>	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	20 No	Specify:			Sp	oecify:Whi	te	
ပ္	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. De	cedent's Usua ive kind of wo	al Occupat	tion	of workin	0		of Business/I		
7	thin in	ם	Elementary/Secondary (0-12)	College (1-4or 5	+)	e. DO NOT us	se retired)	amy most c	or WOIKIII	9				
7	ygier ygier ft, th	S	5		Bus	s Drive						nsport	ation	
밀	be fill d off	Be	17. Father's Name (First, Middle, Last)  Norvel Cooks	017			1			(First, Middle, I reland	Maiden Su	mame)		
$\frac{8}{5}$	ould Mer narke	ပ									27			
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Heelih and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iteme 23a or 28e-f show eny injury or other traumatic event, the Medical Examiner must be notified at QDCs.		19a. Informant's Name/Relationship (Typ							Route Number		own, State, Zi	ip Code)	
<b>a</b>	Heeli Heeli Her		Nancy Wilding (Dau) 20a. Method of Disposition	gnter )	20b. Place of Di	L Roam sposition (Nar.	ne of	-	ings	MD 20		tion - City or Y	own. State	
5	ages int of t: if it		XXBurial 2 Cremation 3 Re	emoval from State	Fort Li	crematory or o	ther place		1/28					
Baltimore,	nit. P artme orten injury	1 4	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licepse	10	TOTE BE			- 1		Lincol		-		
Ba	Depermine Deperm		Alat 1	26: 11-		3401 B1						ood, MI		<u> </u>
			23a. Part1. Enter the disease, or complic	cations that caused	the death. Do not	enter the mod	e of dying	, such as ca	ardiac or	respiratory arr	est,		Approximat	9
	Physician		fmmediate Cause (Final	e cause on each lin	A. HA	1 1	la .	41	1,				Interval Ber Onset and I	ween Death
9	/Medical		disease or condition resulting in death)	Due to lor as a	a consequence of):	2 G	(Z/11.	16111	10				מוקפ	5
	Examiner												1	
		Je	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):									
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
Ö,	e exe	Ë	resulting in death) Last	Due to (or as a	a consequence of):									
8760,	The law requires that the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dlcal	<b>C</b> d											
9	n certific anding p use as	0	IF FEMALE:	20 16										
Вох	eath certif attending for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth	2 Fetal death	3 □Ectopic pr					23d	<ol> <li>Date of deliving</li> <li>Month</li> </ol>		Year
o	the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 ☐ Other (sp	өсіfу)						,	
о. О.	that the de led by the a detached i	F	Part If. Other significant conditions conf	tributing to death bu	it not resulting in th	e underlying c	ause giver	n in Part I.		23e. Did tot	acco use	contribute to	the cause of d	leath?
Vital Records,	uires signe	d b				, ,				1 🗆 Ye	s 2 🗆 N	No ∕3□Pro	bably 4	Inknown
Ö	w requir been si should	lete							_	24a. Was a	. 2	b Wara aut	onsy fin diago	available
Be	he iav e has	Completed								autops	v V	prior to co	opsy findings ompletion of c	ause of
a	icien: Th certificete rector, pag	ပိ	25. Was case referr a to medical	· <u>· · · · · · · · · · · · · · · · · · </u>				00 Disease	(D#-		No	1 🗌 Yes	2 No	
	Attending Physicien: The ir death. ector: After this certificete he by the funeral director, page	ToB	examiner?/	ospital:	nt 2 ER/Outpa	tient 3 DC	Other			Check only on e 5 ☐ Reside		Tothas (Same	MA HOEAL	10
0	g Phy er thi	盲	27. Many or of Death	28a. Date of fnjur (Month, Day			8c. Injury			d. Describe ho			w (tospi	CE
ō	ath. r: Aft	atle	1 ∠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Worth, Day	Year) Inju	M		es 2 □ No	0					
Division of	r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of fnju building, etc	ry - At home, farm,	street, factory	, office		28	Bf. Location (St City or Town		lumber or Rur	al Route Num	ber,
٥	rs efter rei Dire	Ce			. (=#==-//					o., y o	., 0.0.0,			
	To the Hospital or Attending Ph within 24 hours eiter death. To the Funerel Director: After th completely filled in by the funeral	Cal	29a. Certifier 1 Certifying Phys 2 Medical Examin	er: On the basis of	examination and/o	eath occurred investigation.	at the time	, date and p	place, ar	nd due to the ca	ause(s) and	d manner as	stated.	;)
	To the H within 24 To the Fi complete	Medical	one)	and manner sta	ted.								,	,
	To Wit		29b. Signature and title of certifier	1110		290	License	) / m	,	2	od. Date s	igned (Month,	A)	
0	To		IMM NITTE	mu/			190	112			///.	11/1	14	
14	(8)		30. me and address of person where	mpleted cause of de	ath (Itom 23a) (Ty	oe, Print)	K	1 1	B4/	to it	Sil	A 10.	10	
	Sta	10	31. Date filed (Month, Day, Ygar)	32. Registra	r's Signature	WUU4	44		141	0,11	4	ofd,	18	
	Registr		NOV 2 8 2006	4	A Anen	de								

			1 - For State Registrar	State of Marylan		artmen rtificat			and M		giene	$2 \Omega \Omega$	6	3980	7
	Dhusis	:	1. Decedent's Name (First, Middle, Las	st)						2. Date of Dea	ath			3. Time of De	ath
	Physic /Medi		Harry L.	Creighton						Novembe	Day er 1		rear 106	4:45	A M
	Exami	ner	4a. Facility Name (If not institution, give			4b. City,	Town, or	Location of	f Death		4c.	. County of	Death		
			3770 Baptist Chu				jemo	-	24.11=-			harle			
	Funeral Director		5. Social Security Number 6. Security Number 24-9617	ex 7. Age ( <i>in yr</i> s. i	last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Birt (Month, Da	h y, Year)			lace (State or Fo	
-			Usual Residence of Decedent							11/18/1	1926		lash:	ington,	DC
	yland		10a. State 10b. County	10c. City	y, Town or Lo	cation	-						1	0d. Inside City L	imits
	B-1-8	cto	MD Charles	Na	anjemo	У								1 XYes 2	□No
	or 28	Jire	10e. Street and Number			10f. Zip	Code				10g. Cit	izen of Wh	at Coun	itry?	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Inportant: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be natilised at angle.	Funeral Director	3770 Baptist Chui	rch Road		206	62				Uni	ted S	tate	es	
	er deg	nue	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Deced	ent of His	spanic Orig	in? (Spec	cify Yes or No- lican, etc.)		14. Race -	Americ White,		
36	s afte	by F	1 ☐ Never Married 2 ☐ Married  3X☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 ∐WNo If Yes, Give		1 ☐ Yes		Specify:				Specify:	Wh		
21215-0036	hour tural	po	15. Decedent's Ed	Year or Dates:	16a D	d= -40 - 11	10	***							
5	in 72 n" n	Completed	(Specify only highest gra-	de completed)	16a. Dece (Give life. I	kind of wor DO NOT us	nk done d se retired)	uring most	of workin	g	16b. Ki	ind of Busi	ness/Inc	lustry	
212	filed within 7 Hygiene. other than "r ent, in Myd	E	Elementary/Secondary (0-12)	College (1-4or 5+)		tenan					Mar	yland	Uni	iversity	7
0	Hyg other	BeC	17. Father's Name (First, Middle, Last)		Haili	Cenan	CE W		r's Name	(First, Middle,	Maiden	Sumame)			
a	lid be ked c	To B	James Arthur					Cor	a Saı	unders		,			
Maryland	should ind Men marke	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	g Address	(Street a			Route Numbe	r, City o	r Town, St	ate. Zip	Code)	
	and 2 ealth a n 27 is		Arthur Creighton	(brother)		Vern				Plata,					
Baltimore,	of He item		20a. Method of Disposition	20b. Pl	lace of Dispo	sition (Nam	ne of		Da	ite	20c. Lo	cation - Ci	ty or To	wn, State	
Ĕ	Pages nent of int: If it		1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify						11/22	2/2006	Brei	าะพาก	a.m	)	
aĦ	permit. Depertr Imports any inju		21. Signature of Funeral Service Licent		22	. Name an	d Address	s of Facility	Fort	Linco	1n ]	Funer	al F	lome	
m	88 = 8		Keehed Thom	7/				nsburg		_				20722	
	Physician /Medical Examiner		23a. Part1. Enter the disease, accompshock, or heart failure. List only of the disease or condition resulting in death)	plications that caused the death one cause on each line.  Lung Cance a.  Due to (or as a consequ	r	er the mode	e of dying	, such as c	cardiac or	respiratory an	rest,			Approximate Interval Between Onset and Deat 1 year	
	uted	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequ	ence of):										
8760,	icate be executed physicien and s the burial-transit	Ilcal Exa	resulting in death) Last	Due to (or as a consequent)	ence of):										
D. Box 6	The law requires that the death certificate be executed site has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 [	Ectopic pre					2	23d. Date o Month		y Day Year	
P.0	that the	F.								T				v	
ords,	w requires t been signe should be o	ted by	Part II. Other significant conditions co	with but not resu	nung in the ur	idenying ca	iuse giver	n in Part I.			es 2[			e cause of death	
of Vital Records,		Completed								24a. Was a autops perform	sy med?	prio dea	r to com	sy findings avail pletion of cause 2 No	able of
/its	iclan: certific rector,	Be	25. Was case referred to medicat examiner?						of Death	Check only on	ie)				
<b>J</b> C	Physiclan: this certificant director, is	၉	1 1 1 1 1 1 2 2 XX 1 1 4 0	Hospital: 1 ☐ Inpatient 2 ☐ E				4 - 14012	sing Home	∋ 5 Reside	ence 6	Other (	Specify,		
Division (	arding ath. or: After ne funer	Certification:	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28b. Time of Injury	M 28	Bc. Injury : Work?	at es 2 ⊡No		d. Describe he	ow injury	occurred			
Divi	or after Dir.	Certifi	3 Suicide 6 Could not be determined	building, etc. (Specify)	)					City or Town	n, State)			Route Number,	
	the Hospital hin 24 hours the Funeral npletely filled	ledical	one) 2 Medical Exam	rsician: To the best of my know iner: On the basis of examinati and manner stated.	viedge, death ion and/or inv	occurred a estigation,	it the time in my opii	e, date and nion, death	place, an occurred	d due to the call at the time, d	ause(s) ate and	and manne place, and	er as sta I due to	ited. the cause(s)	
_	T Som	Σ	29b. Signature and title of certifier	20			License					signed (A		lay, Year)	
Γ			INVI				2734			1	11/2	2/200	06		
12	-(10)		30. Name and address of person who c Howard Haft, MD				Wa	ldorf	, MD	20602					
	Sta Registr	te ar	31. Date filed (Month, Bay 2006	32. Registrar's Signatu											

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland /		ficate of L			.2006	39808
П	Physici		1. Decedent's Name (First, Middle, Last)			0 = 4	1540	2. Date of Death Month D	ay Year 2006	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution; give st	. 11 1:1.1	4	b. City, Town, or	Location of Death		c. County of Death	1
	Funeral		The Johns Hork 5. Social Security Number 6. Sex	7. Age (In yrs. last		DA HIMO f Under 1 Year	If Under 24 Hrs. 8	B. Date of Birth	9. Birth	place (State or Foreign
	Director		3/9-92-9009	<sup>M 2□ F</sup> 39	Yrs.	flonths Days	Hours Min.	B. Date of Birth (Month, Day, Yea DEC 21 1	966 WAS	HINGTON, DC
	yland now at		Usual Residence of Decedent  10a. State  10b. County	10c. City, To	own or Locat	ion	7.11			10d. Inside City Limits
	ne Mar 8a-fsh otified	ector	MD PRINCE GEO	ORGE'S UI		ARLBORO		T to a		1∭Yes 2 No
	3a or 2	l Dir	10e. Street and Number 8400 GRAND HAVEN	AVENUE		10f. Zip Code 2077	72	10g. C	Citizen of What Cou	•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	y Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:		s Decedent of Hi es, specify Cuba Yes 2 X No	spanic Origin? (Spec n, Mexican, Puerto R Specify:	fy Yes or No- can, etc.)	14. Race - Amer Black, White Specify: BL	, etc.
21215-0036	72 hour natural lical Ex	Completed by	15. Decedent's Educ	ation 1	6a. Deceden	it's Usual Occupa	ation turing most of working	16b.	 Kind of Business/I	ndustry
121	within ene. than "	Juple	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retired, NGINEER	furing most of working )		GOVERNME	NT
	e filed with al Hygiene. I other thar vent, the N	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name (			
Maryland	2 should be filed and Mental Hygi Is marked other aumatic event, ti	10	CARL HOLLINGSWORTH  19a. Informant's Name/Relationship (Typ)	o Brint)	10h Mailing	Address (Street s	WILLIE and Number or Rural	JONES	as Town Chair 7	i- Codol o o
	1 and 2 sl Health an em 27 Is r other traur		REGINA ELLIOTT CEA	SAR/WIFE 8	8400 G	RAND HAV	VEN AVENUE	UPPER MA	RLBORO , M	ARYLAND
Baltimore,	Pages 1 annument of He		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ Re	moval from State ceme		on (Name of tory or other place EMETERY	<sub>е)</sub> Da		Location - City or NDOVER, M	
altin	permit, Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Laurent Service License		22. N	lame and Addres	ss of Facility J.	B. JENKIN	S FUNER	AL HOME
8	6 2 E 6 6		22a Parti Spier the diagram or complic	ation at sourced the death. F			VER ROAD L		IARYLAND	20785 Approximate
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	cause on each line.  Due to (or as a consequent	DRAL	Hemo	whee	respiratory arrest,		Interval Between Onset and Death
	Examiner	_	Sequentially list conditions, b.	State to (or as a consequence						le days
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to intribudate cause. Enter Underlying Cause (Disease or injury that initiated events	LEFT VENTA	Ricula	AR AR	prest de	lice		2 WEEKS
68760,	tificate be executed ig physician and as the burial-transit		resulting in death) Last	Due to (or as a consequent	ice of):	,				
	rtificate ng phys	Medical	IF FEMALE:							
P.O. Box	The law requires that the death certate has been signed by the attending agge 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	ic. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	eath 3 □ Eo	ctopic pregnancy other (specify)			23d. Date of deli Month	very Day Year
Records, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions conf	ributing to death but not resultin	ng in the unde	erlying cause give	en in Part I.	23e. Did tobacco		the cause of death?
al Reco		Completed						24a. Was an autopsy performed? 1∐ Yes 2 ☑	/ death?	lopsy findings available ompletion of cause of
·Vital	Physician: this certificral director, p	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 ☑ Inpatient 2 ☐ ER/	/Outpatient	3 DOA Othe	26. Place of Death ( er: 4□ Nursing Home	Check only one)  a 5 ☐ Residence	6 ∏Other (Spec	ifv)
n or			27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28	Bb. Time of Injury	28c. Injury Work	/ at 28	d. Describe how inj		,
Division	tor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home building, etc. (Specify)	e, farm, street		Yes 2 □No 28	f. Location (Street a City or Town, Sta	and Number or Ru te)	ral Route Number,
_	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical Ce	29a. Certifier (Check only one) 1 ☐ Certifying Phys 2 ☐ Medical Examin	ician: To the best of my knowleder: On the basis of examination	edge, death o	ccurred at the tin stigation, in my o	ne, date and place, ar pinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	29d. D	ate signed (Month	, Day, Year)
			•	- MV		RES-	000	Non	EMBER.	24,2006
R	(5)		30. Name and address of person who con	npleted cause of death (Item 23	3a) (Type, Pri )() (	St. Ba	Himpes, 1	HARYLAM	lember.	7
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) NOV 2 9 2006	32. Registrar's Signature	out!	150 11	11000	111111111111111111111111111111111111111	× · (/ -5 ,	

Please Type or Print in Black Indelible Ink Charles Benjamin Carr, IV State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month **Medical Examiner** Charles Benjamin Carr, IV 0140 hrs November 24, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Glen Isle Rd./ Riva Rd. Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24Hrs. Funeral If Under 1 Year 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Days Director Months Hours 214-13-3820 20 TXXM 2 F 1986 Country) Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Edgewater or 28a-f show 1 Yes 2 X No must be notified at once. death with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 Park Avenue 21037 U.S.A. 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. 1 X Never Married 1 Yes "natural", or permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. If item 27 is marked other than "natural", o 4 Divorced If Yes, Give Year 2004-2006 White 1 Yes 2 X No specify Specify ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical **Baltimore**, MD 21215-0036 Midshipman/Student US Naval Academy 2 Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Charles W. Carr Patricia Cullinane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) rtant: If item 27 is Charles W. Carr/father 111 Park Avenue Edgewater, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Naval Academy Cemetery 11/28/2006 Annapolis, Maryland 4 Donation 5 Other Specify 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signa - Funer IS rvice Liee 147 Duke of Gloucester St., Annapolis, MD 21401 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Multiple Injuries Death Examiner Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical physician a UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Day Month Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 1 🗸 Yes 25 Was case referred to medical 26.Place of Death (Check only one) Be Other<sub>4</sub> Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes

To the Hospital or Attending Physician: After this Certification: 24 hours after death. To the Funeral Director: Medical

27. Manner of Death 28a. Date of Injury (Month, Day Year) Nov 24, 2006 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Passenger auto fixed object collision Natural 0132 hrs 5 Pending Yes 2 V No 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Glen Isle Rd./ Riva Rd., Riva, Md. determined (Specify) Local Street 4 29a Certifier 1

O.C.M.E.

November 24, 2006

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person w o completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

32. Redistrar's Signature State

Carol Allan, MD

Registrar

			For 1 _ State	State of Maryland / Dep		Mental Hygier	ne	20010
			Registrer  1. Decedent's Name (First, Middle, La.		ertificate of Death	Reg.	NE UUD	3 70 I U
	Physici		1. Decedent's Name (Pirst, Middle, La.	the one Clauton			Day Yeer	347 A M
	/Medic Examin		4a. Facility/Name (If not institution, give	e street and number)	4b. City, Town, or Location of Death	Carlow Co.	4c. County of Death	31771
	LXamii		Harford Memor	ical Hospital	Havre de Grace		Hartord	
	Funeral		5. Social Security Number 6. S	Tu .M = 77	/) If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	(Month, Day, Ye	9. Birthpl Count	ace (State or Foreign
	Director		2(9 - 22 · 8353   1	Yrs.		109-19-11		yland
	ow ow		10a. State 10b. County	10c. City, Town or L	ocation.		10	Od. Inside City Limits
	a-fsh	tor	Maryland Harford	d Haure de	e Grace			1 X Yes 2 ☐ No
	or 28	)ire	10e. Street and Number		10f. Zip Code 2 ( 078	10g.	Citizen of What Coun	try?
	ath w	ral	460 Battery L	onue		<u>U</u>	11(00)	es
	Item Item	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 🗷 No	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	14. Race - America Black, White, e	
936	72 hours after death with the Maryland neturel; or Items 23e or 28a-f show Iteal Evanil writnest be inclifted at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 M No Specify:		Specify: (1)	nite
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 ie marked other then "neturei", or Items 23e or 28a-f show other treumetic event. The Medical Evairil artmant ke notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation 16a. Dec	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	rking 16b	. Kind of Business/Ind	lustry
121	filed within Hygiene.	Idm	Elementary/Secondary (0-12)	College (1-4or 5+)			ivil Servi	. 0
	filed within Hygiene. other then		17. Father's Name (First, Middle, Last,	, C   C   Y   V	neering lechnician  18. Mother's Nar	me (First, Middle, Maid		CE
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ary	shou ind M mar umet	-	19a. lieformant's Name/Relationship (	Туре, Print) 19b. Маі	ling Address (Street and Number or Ru	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Code)
	1 and 2 Health a lem 27 id		Vincent Clayton	The state of the s	battery Drive Haure	1100	Maryland	2.1078
Baltimore,	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disposition U 1 □ Burial 2 ☑ Cremation 3 □	Hemoval from State	ematory or other place)		Location City or To	1
ţ			`4 □Donation 5 □ Other (Specif	R.A. Fern		o-2006 we		
Ba	permit. Departr importa eny inj		21. Signature of Funeral Service Lice		22. Name and Address of Facility Nitchell "Smith Fun	eral Hane,		race Maryland
			23a. Part1. Enter the disease, or con-	plications that caused the death. Do not en	23 South Weshington nter the mode of dying, such as cardiac	or respiratory arrest,	House de G	Approximate
, iii	Physician	5	shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	claratic Carolistone	0,1.		Interval Between Onset and Death
4	/Medical		disease or condition resulting in death)	ue to (or as a consequence of):	succes Canada Care	wite o	il.	
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Ž	al-trar	Examine	that initiated events resulting in death) Last	c Due to (or as a consequence of):				
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and orgoe 2 should be detached for use as the burial-transit	dlcail		_ d				
9	ng ph		IF FEMALE:					
Вох	leath certific attending p I for use as	lan/I	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy		23d. Date of delive Month	ry Day Year
0	he dear the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 5 9☐Unknown	Other (specify)			,
0	es that the de gned by the a be detached to		Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to th	e cause of death?
Records,	quires in sign uld be	ed by	Dealetes			1 🗆 Yes	2 No 3 Proba	ably 4 □Unknown
ဝင္တ	re law requir has been s ge 2 should	plet	Dementia			24a. Was an autopsy	24b. Were autop	osy findings available appletion of cause of
Ä		Completed				performed	? death? No 1 ☐ Yes	2 <b>/2</b> No
Vital	yeicien: The is certificate director, pag	Be (	25. Was case referred to medical examiner?	[ Americal		ath (Check only one)		
of	di is	٦.	Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ER/Outpatient 28a. Date of Injury 28b. Time		lome 5 Residence		)
	ding In. After funer	tlon	1 Natural 5 Pending 2 Accident investigatio	(Month, Day Year) Injury		234, 2030/180 /101/1	nary coodinad	
Division	Atten r deal ector: by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s	street, factory, office	28f. Location (Street City or Town, St	and Number or Rura	Route Number,
Ö	s afte	Cert	4   Homicide	building, etc. (Specify)		City of Town, St	a( <del>0</del> )	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral		(Check only 2 Medical Exe	nysician: To the best of my knowledge, deaniner: On the basis of examination and/or	ith occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the cause arred at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
	thin 2.	Medical	29b. Signature and title of certifier	and manner stated.	29c. License number	29d.	Date signed (Month, I	Day, Year)
	¥ × × 8		B 011/1/	a VIA Aur	10014206			,
	(		30. Name and address of person who	completed cause of death (Item 23a) (Type			confer 5, 2	-E/U C
	H		BERNARD J. YUKM	MIN DIME 1614 CHYNCH	WILLE Ad BELA	IR Md 210	15	
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature	WILLE Ad BELA	1		
	Regist	III.	DEC 1 4 20	INO THE WORKER NOT 198	- P. (1955)			

			1 - For Stete Registrar	State of M	aryland /		artmen rtificate			ınd M	ental Hy	ygier Reg. i		)	39811
	Physici	20	1. Decedent's Name (First, Middle, Last,							1	2. Date of D Month		Day Y	'ear	3. Time of Death
	Physici /Medic		Orval Will:		Dodg	ge					Nov.	28,	2006		10:00 P M
	Examin	er	4a. Facility Name (If not institution, give Garrett County Men				4b. City,		Location of	f Death		1	4c. County of		_
			5. Social Security Number 6. Se		ge (In yrs. last	hirthday)	If Under	Oak]	Land If Under 2	24 Hrs.	8. Date of B	irth	Gar		place (State or Foreign
	Funeral Director		217-30-1336	ŜM 2□F	77	Yrs.	Months	Days	Hours	Min.	(Month, D	av. Yea	ar)	Cou	virginia
	D		Usual Residence of Decedent												
	anylan show	Ļ	10a. State 10b. County		10c. City, To	own or Lo									10d. Inside City Limits 1 ☐ Yes 2 X No
	Ba-f s	Director	MD Garre	ett			0ak1					40-	0.00		
	with the	吉	10e. Street and Number				10f. Zip					10g. (	Citizen of Wh		ntry?
	eath te 23	eral	7446 Gorman Road	12. Was Decedent	Ever in U.S.	13	Was Deced	215		un? (Spe	cify Yes or N	0-	USA 14. Race -		can Indian,
·0	r Rend	Funeral	1 ☐ Never Married 2 🕅 Marned	Armed Forces 1 XYes 2 □	? No					Puerto I	cify Yes or N Rican, etc.)		Black,	White,	
Ö	ral', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	62-63		1 ☐ Yes :	2LX No	Specify:				Specify:		White
2	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itema 23a or 28a-f show ent, Ira Medical Examinat must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		16	(Give	dent's Usua kind of wor	rk done d	luring most	of workii	ng	16b.	Kind of Busi	ness/in	ndustry
2	within	ldm	Elementary/Secondary (0-12)	College (1-4or	5+)		<i>DO NOT</i> us <b>arpen</b>	,	)				Constr		ion
2	Hygie ther ther	ပိ	17. Father's Name (First, Middle, Last)				arpen	CCI	18. Mother	r's Name	(First, Middl	_	on Sumame)		.1011
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show says injury or other traumatic event, It a Medical Examinar ment be notified at ance.	To Be	Jacob Frankli		dge					ith		aud		ets	
Mar	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (T) Elizabeth M. Dodge	-							ind, Ma		y or Town, St	are, 21, 2155	
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altimore,	ages ant of at: If It		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		9		matory or o netery		1	12/1	/06	0al	kland,	Ma.	rvland
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ă	Ped die		> Bushen H	Soul		St	ewart	Fun	eral	Home	Oakla			2155	0
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8760,	ate be hysici the bu	dical		d										-	
9 ×	leath certifica attending ph i for use as t	0	IF FEMALE:	23c. If yes, outcom	o of prognancy										
Вох	attend for us	Physician/M	in the past 12 months?	1 Live birth	2 ☐ Fetal dea at time of death		Ectopic pr						23d. Date Month		ery Day Year
o.	that the de led by the a detached f	yslo	1 □ Yes 2 ☑ No 9 □ Unknown	9☐ Unknown			_ O (1) O (3)								
<u> </u>	The law requires that the tie has been signed by th bage 2 should be detache	þ	Part II. Dther significant conditions co	ntributing to death	but not resultin	g in the u	nderlying c	ause give	en in Part I.						he cause of death?
Š	w requires t been signe should be	etec					V-V-t-t-				24a. Wa				
Records,	he lav e has ige 2	Completed									aut	opsy formed	? de:	or to co ath?	opsy findings available empletion of cause of
Vital		e C	25. Was case referred to medical						26 Place	of Death	1 Yes (Check only		NO 1L	Yes	2 No
<u> </u>	Physician: r this certific ral director,	0 8	examiner?	Hospital: 1 9 Inpat	ient 2□ER/	Outpatie	nt 3 DC	A Othe	200				6 □Other	(Speci	fy)
on of	Attending Phir death.  ctor: After thi	tlon: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D	ury 281	b. Time o Injury	f 2	8c. Injury Work	rat c? Yes 2 □ N		28d. Describe	how in	njury occurred	1	.,
Division	I or Attendate after death Director:	ertification:	3 Suicide 6 Could not be 4 Homicide determined	289. Place of II	njury - At home ntc. (Specify)	, farm, st	reet, factory	, office			28f. Location City or T			or Run	al Route Number,
_	Hospital 4 hours Funeral ely filled	edical Co	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the bes	of examination	dge, deal and/or ir	h occurred vestigation	at the tim	ne, date and pinion, deat	d place, a	and due to the	e cause	o(s) and manr and place, an	ner as s	stated. o the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	- Indilitel S			290	. License	number			29d. l	Date signed (	Month,	Day, Year)
	~ > r= 0		1 Am	~~	xx	$\sim$		1) 4	124	66	4	11	1301	16	6
-			30. Name and address of person who c	ompleted cause of	eath (Item 23	a) (Type,	Print)						1		7
			Sotiere Savopoula		55 N. F		h St.	, 0a	kland	, Ma	ryland	2	1550		
	Sta Regist		31. Date filed (Month, Day, Year)  DEC -	1 2006 32. Regis	trar's Signature	A. S.	90	chi							

		•	1 - For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of H tificate of L	ealth and M Death		ene	06 3	98	12
	Dhysioi	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	n Day	Year 3.	. Time of D	
	Physici /Medic		Andre Brian Di					11	19		629	P M
	Examin	er	4a. Facility Name (If not institution, giv				Location of Death			ty of Death		
			Fort Washington 5. Social Security Number 6.5		. last birthday)		ashington   If Under 24 Hrs.	8. Date of Birth	Prir	nce Geor		Foreign
	Funeral Director			1⊠M 2□F 38	Yrs.	Months Days	Hours Min.	(Month, Day, 06-10-		9. Birthplace Country)	NY	or orgin
	D		Usual Residence of Decedent					00 10				
	arylar show	_	10a. State 10b. County		ity, Town or Lo						Inside City 1 <b>2</b> Yes 2	
	Ba-f	Director		Georges F	ort Was	hington		1/	n Citinan a	f What Country?		
	with I	ä	10e. Street and Number 6541 Buckland	Court		10f. Zip Code 2074	1/1			d State		
	ne 23	Funerai	11. Marital Status	12. Was Decedent Ever in	U.S. 13. 1			ecify Yes or No-		ace - American Ir		
0	r tten	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No	1	Was Decedent of H		Rican, etc.)		ack, White, etc.		
2	rel', o	d b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Spec	ity: Black		
21215-0030	d within 72 hours after death with the Maryland jiens	Completed	15. Decedent's E (Specify only highest gr		(Give	dent's Usual Occupi kind of work done	during most of work	ing	16b. Kind of	Business/Industr	ry	
7	within ane.	d L	Elementary/Secondary (0-12)	College (1-4or 5+) 2		DO NOT use retired	,		F	+ / D		
N	be filed and that Hygie of other is		12 17. Father's Name (First, Middle, Last		Insta	allation	18. Mother's Nam		_	tar/Priv	vate_	
-	0 = 5	То Ве	Robert Dixie				Sandra	a Hannah				
Maryland	es 1 and 2 should be of Health and Menta fitem 27 is marked r other traumatic ex	-	19a. Informant's Name/Relationship	Type, Print)	19b. Mailir	ng Address (Street			City or Tow	n, State, Zip Coo	de)	
	and 2		Sabrina M. Dixie	/Wife	6541	Buckland	Court, I	ft. Washi	ington	, MD 207	744	
Baltimore,	of He of He fitem		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐	)	Place of Dispo cemetery, cres	sition (Name of natory or other place		Date 2	20c. Location	- City or Town,	State	
Ě	permit. Pages t Department of H Important: If Ite any Injury or ot once.		4 □Donation 5 □ Other (Speci		esurrec	tion Ceme	etery 11-	25-06	Clint	on, MD		
ğ	ermit.		21. Signature of Funeral Service Lice	nsee		. Name and Addres						P.A
_	00340		23a. Part1. Enter the disease, or con	rickland		500 Aller					0748 proximate	
	Certificate be executed with a physician and wing physician and itse as the burial-transit	licai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Hemoptysis Due to (or as a conse b. Cavitary I Due to (or as a conse c. Sarcidosis Due to (or as a conse d.	quence of): Lung Di queres of):	sease				On	set and De	eath
Ø	ding p	/Mec	IF FEMALE:	23c. If yes, outcome of pregr	nancy				004.5			
O. Box	death e atter	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fell 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)				ate of delivery fonth Day	y Ye	ear
ds, P.	80 25 80	ρ	Part II. Dther significant conditions	contributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.		acco use co	ntribute to the ca		
Vital Records,	w requir been si should I	Completed						24a. Was ar	24b	. Were autopsy	findings av	vailable
Ä	he la e has age 2	шc						autopsy	ned?	prior to comple death?	tion of cau	use of
<u> </u>		0	25. Was case referred to medical		<del></del>		26. Place of Deat	1 ☐ Yes 2 th (Check only one	![x\No	1 ☐ Yes 2 ☐	NO	
₹	yeici iis cer direc	To B	examiner? 1 ⊡xYes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3□ DOA Oth	0.0	ome 5 🗆 Reside		ther (Specify)		
Division of	Attending Physician: It death. Sector: After this certification in the funeral director.		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur Wor	y at k?	28d. Describe ho	w injury occ	urred		
Sio	Attendi er death. rector: A by the fu	cati	2 Accident investigation 3 Suicide 6 Could not I				Yes 2□No	201 1 1'- 101				
<u>&gt;</u>	i Sign	Certification;	4 Homicide determined			eet, factory, office		28f Location (Str City or Town		nder or Hurai Ho	ute Numb	er,
	Hospital 4 hours a Funeral I		29a. Certifier 1 Certifying P	hysician: To the best of my kr	nowledge, deat	h occurred at the tin	ne, date and place,	and due to the ca	use(s) and r	manner as stated	d.	- 90
	To the Hospital within 24 hours a To the Funeral I completely filled	edical		minar: On the basis of examinand manner stated.								
	To the within 2 To the complet	Me	29b. Signature and title of certifier	~		29c. Licens	e number	29	9d. Date sign	ned (Month, Day,	, Year)	
	3.		la anni	5100 Just	Two	155	507		11/2	2/06		
	5. BJ		30. Name and address of person who	completed cause of death (Ite	ет 23а) (Туре,	Print)						
			Dr. Wayne P. Day	vis 2041 Geor	gia Ave	nue, NW,	Washingt	on, DC 2	0060			
1	Sta Regist	ate rar	NOV 2 8 2006	32. Registrar's Signature	est							

			For 1 State	State of Ma	aryland				Mental Hy	giene	006	39813
			State     Registrar  1. Decedent's Name (First, Middle, L.)	251)		Cer	tificate of	Death	2. Date of Dea	Reg. No.		3. Time of Death
П	Physici		James Do						Month	26	2006	1-46
	/Medic Examin		4a. Facility Name (If not institution, gr	-			4b. City, Town, o	r Location of Deat	th		ounty of Death	
			Brinton Woods	Nursing &	Rehab	. Ctr	Sykes	ville			Carrol	1
	Funeral			Sex 7. Ag 1XXM 2□F	e (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, Day	h v. Year)	Col	hplace (State or Foreign untry)
	Director		213-38-9475 Usual Residence of Decedent		100	113.			June 2.	3, 19	906 Ma	ryland
	yland how		10a. State 10b. County		10c. City,	Town or Loc	cation					10d. Inside City Limits
	e Mar	ctor	MD Carro	011		Syke	sville					1 ☐ Yes 2 🙀 No
	vith th	Director	10e. Street and Number	D 1			10f. Zip Code	4.70 /			en of What Co	
	eath v	erai	1442 Buckhorn	12. Was Decedent	Ever in U.S.	13 V		1784	Specify Ves or No-		ed Sta	
"	filed within 72 hours after death with the Maryland Hygiene. uthar than "natural", or Itams 23a or 28a-f show ant, the Medical Examinar must be motified at	by Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ 🕽		If		an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		Black, White	
21215-0036	ral', o	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2/2/No	Specify:		S	Specify: W	hite
5	"natu	Completed	15. Decedent's f (Specify only highest g			(Give I	ent's Usual Occup	during most of wo	rking	16b. Kind	d of Business/f	ndustry
2	withir ene. than	dmc	Elementary/Secondary (0-12)	College (1-4or 5	5+)	III. L	O NOT use retired Attornes	y/Lawyer		Va	ınS1vke	& Doyle
Ď 2	illed Hygi othar	Be Co	17. Father's Name (First, Middle, Las	(t)				,	me (First, Middle,			
<u>lar</u>	uld be Menta Menta Irked Itic av	To B	James Doyle	Jr.				Sarah	Virginia	a Hod	lges	
Maryland	2 sho and I Is me		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street	and Number or R	ural Route Numbe	r, Cify or	Town, State, Z	ïp Code)
	l and lealth Im 27 Iher ti		James Doyle IV 20a. Method of Disposition	Son	20h Pla		Green M	ill Road	Finksbu		MD 210 ation - City or T	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant, the Medical Examinar must be rutified at once.		1 Burial 2 Cremation 3		сеп	netery, crem	atory or other place		ov. 27, 2			eld, MD
ᄩ	nit. P. artme ortani injury		* 4 □ Donation 5 □ Other (Special Signature of Funeral Services Lice		boat	22	Name and Addre	ss of Facility				
m	Depa Impo any ir		Janu 130	aur		Bi	urrier-Ou	ueen Fund	eral Home ty Road	e & C Winf	remato	ry, PA MD, 21784
			a. Pa 1. Enter the disease, or consock, or heart failure. List on	mplications that caused y one cause on each	the death.						1010,	Approximate Interval Between
	Pnysician		Im ediate Cause (Final ease or condition	1 4	tylia	un.	Diseis	100				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a nseque	nce of):						1
	Design !	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	nce of):						
	ficate be executed physician and is the burial-transit	Examiner	cause. Enter Underlying Cause Ultrane or injury that initiated events									
oʻ	cate be executed physician and the burial-transit	Еха	resulting in death) Last	Due to (or as	a conseque	nce of):						
8760,	ate be	dicai	•	d								
9	= 0,4		IF FEMALE:	23c. If yes, outcome	of pregnanc	ev.					Id Data of doll-	
Box	es that the death certifi igned by the attending be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ₩6	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal d	leath 3 🗌	Ectopic pregnancy Other (specify)	1		23	Id. Date of deli- Month	Day Year
ö	t the c by the	hysi	9 Unknown	9□ Unknown						ŀ		
s, P	The law requires that the site has been signed by th bage 2 should be detache	ру Р	Part II. Other significant conditions	contributing to death b	ut not result	ing in the un	derlying cause giv	en in Part I.	23e. Did to	bacco use		the cause of death?
ord	w requir been sl should	ted							1 T	es 2 🗆	No 3☐ Pro	obably 4 Hunknown
Sec.	e law has b	Completed							24a. Was a autop perfor	sv	24b. Were aut prior to co death?	topsy findings available ompletion of cause of
Vital Record									1□ Yes	2 19 No		2 No
		o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	nt 2□ E	R/Outpatient	3□ DOA Oth	or /	ath <i>(Check only or</i> Home 5 🗆 Resid		Other (See	1/6.1
of		n: To	27. Manner of Death	28a. Date of Inju (Month, Da	ry   2	8b. Time of Injury	28c. Injur	v at	28d. Describe h			ny)
ior	anding I sath. or: After he tuner	atio	1 Accident 5 Pending investigation	on	y roar)	milary		Yes 2 □ No				
Division	or Atta iter de iracto n by ti	ertification:	3 Suicide 6 Could not determine		ury - At hom c. (Specify)	ie, farm, stre	et, factory, office		28f. Location (S City or Tow		Number or Rui	ral Route Number,
	pital o	O	29a. Certifier 1 Certifying F	hypician, To the best	of my knowl	adaa daath	accurred at the tim	no data and place	and due to the e	2000(2) 20		atatad
	To the Hospital or Attanding within 24 hours after death.  To tha Funeral Diractor: After completely filled in by the fune	edical	(Check only one)	hysician: To the best miner: On the basis of and manner sta	examinatio	n and/or inv	estigation, in my o	pinion, death occu	urred at the time, o	ause(s) ai date and p	lace, and due	to the cause(s)
	To the within To the compl	Me	29b. Signature and little of pertifier				29c. Licens	e number	2	29d. Date	signed (Month	, Day, Year)
}	WIL		1 fature 1				105	0806		11/	127/06	
	6		30. Name and address of person who	eempleted cause of d	eath (Item 2	23a) (Type, F	Print R	d EI	dersburg	1 M	ID 2	1784
	Sta	te	31. Date filed (Month, Day, Year)	32. Record	ar's Signatur					-	0	
	Registr	ar	NOV 2 8	2006	eur.	N. A	parti					

			Character of Mandard / D	indelible ink. Ensure All Copies	Are Legible.
			1- For Amend#26,30 Per FH State of Maryland / De	epartment of Health and Mental Hy	giene ang sasil
			Registrar AACO HEALTH DEPT 11/2//06 CVH	Dertinicate of Death	Reg. No.
1	Physici	an	Decedent's Name (First, Middle, Last)  C ~ \	2. Date of De. Month	Day Year
	/Media		Eileen Margaret D	oiller 11	23 66 12:02 am
14	Examir	er	4a. Facility Name (If not institution, give stree and number)	4b. City, Town, or Location of Death	4c. County of Death
	**	# ·	1046 Old County Road	Severna Park  day) If Under 1 Year   If Under 24 Hrs.   8, Date of Bin	Anne Arundel
н	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 119–48–7487 51 YI	Months Days Hours Min. (Month. Da	9. Birthplace (State or Foreign Country)  CA
distance	Director		Usual Residence of Decedent	Aug.	, 1993 CA
	yland		10a. State 10b. County 10c. City, Town		10d. Inside City Limits
	Mar.	tor	MD Anne Arundel	Severna Park	1 ☐ Yes 2 € No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	hours after death with the Maryland tural', or ttems 23a or 28a-f show at Establical mast be notified at		1046 Old County Road	21146	USA
	r dea	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> </ol>	- 14. Race - American Indian, Black, White, etc.
36	or it	by Fu	1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2 🙀 No If Yes, Give	1 ☐ Yes 2X No Specify:	Specify: White
Ö	72 hours natural',	d b	3 Widowed 4 Divorced Year or Dates:	Deceder's Usual Congretion	10b Kind of Pusingson/Industry
15	n 72 ho	jet	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of working ife. DO NOT use retired)	16b. Kind of Business/Industry
12	d within piene. r than	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	n-Profit Administrator	Partners-In-Care
p	Hygent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	Maiden Sumame)
<u>a</u> n	D 2 2 0	To B	John Muller	Margaret McCu	ısker
Maryland 21215-0036	shound h		19a. Informant's Name/Relationship (Type, Print) 19b. I	Mailing Address (Street and Number or Rural Route Number	er, City or Town, State, Zip Code)
	1 and 2 Health a em 27 ly			046 Old County Road, Severn	na Park, MD 21146
Baltimore,	ges 1 and t of Healt if item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	Disposition (Name of crematory or other place)  Nov. 27,	20c. Location - City or Town, State
Ē	Par ant:		4 Donation 5 Other (Specify) Metro	Crematory 2006	Baltimore, MD
Salt	permit. Pag Department Important: any injury once.		21. Signato e of Ameral Service Licensee	22. Name and Address of Facility Barranco & Sons, P.A. Seve 495 Gov. ritchie Hwy, Seve	erna Park Funeral Home
<u></u>	40 E # 0		I Thomas HILL		
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.		Interval Between
9.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	rocular accid	ert
	Examiner		Due to (or as a consequence of	):	
		-e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
	uted ansit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events c.	ligid ama	
Ć.	te be executed ysicien and e burial-transit	Exa	resulting in death) Last  Due to (or as a consequence of		
760	te be ysicie ne bur	cal	la averi	OSCLEROSIT	
68	rtificate ng phys as the	Physician/Medi	IF FEMALE:		
Вох	eath cert attending for use	an/l	23b. Was decedent pregnant in the past 12 gronths?	3 ☐ Ectopic pregnancy	23d. Date of delivery  Month Day Year
	at the dea by the at stached fo	sici	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 9 Unknown	5 Other (specify)	World Day 1941
P.O	that the		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part ! 23e Did t	obacco use contribute to the cause of death?
ds,	Se Log	l by	COPO Alleger Report	7 101 780	
of Vital Record	w requir been si should	Completed	The same of the	60	
Rec	The lav	E D	afford any total smy when	24a. Was autor	
a	@ <del>1</del>	e Co	25. Was case referred to medical	The folly a mau Yes	2 No 1 Yes 20 No
5	Physiclan: this certific ral director,	œ o	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	6. Place of Death Check only of Death State 3 DOA Other: 4 Nursing Home 5 Resident	dence 6 Other (Specify)
	orthi	I -	27. Manner of Death 28a. Date of Injury 28b. Tir	me of 28c. Injury at 28d. Describe I	now injury occurred
<u>o</u>	Attending F r death. ector: After by the funer.	atio	1 ZNatural 5 Pending (Month, Day Year) inj 2 Accident investigation	work?  M 1 Yes 2 No	
Division	or Attend after death Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office 28f. Location ( City or Tou	Street and Number or Rural Route Number, vn. State)
	ital o irs aft ral Di led in				
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical Examiner: On the basis of examination and	Jeath occurred at the time, date and place, and due to the or investigation, in my opinion, death occurred at the time,	date and place, and due to the cause(s)
	To the within 2. To the complet	Mec	29b. Signature and male of sentier	29c. License number	29d. Date signed (Month, Day, Year)
	⊢≰⊢ŏ		· Illa	DOD 61864	11/27/0
7			30. Name and address c/person who completed cause of death (Item 23a) (T	ype, Print) Felicia Carcia Mil	21108
	15		8601 Vetuans Hishway	stell millersvil	le mo 2408
4/3	Sta		31. Date filed (Month, Day, Year) 32. Degistrar's Signature	4	
	Regist	rar	2000	Society 1	

						partment of F				
			1 - For State Registrar	0.0.0 0		ertificate of			2006	39815
		2	Decedent's Name (First, Middle, Las	t)				2. Date of Deat Month		3. Time of Death
Some	Physici /Medic				DOTSON			NOV. 2	2006	6:15 P M
	Examin	ner	4a. Facility Name (If not institution, give				Location of Death	1	4c. County of Dea	th
	Funeval		Joseph Riches 5. Social Security Number 6. Se		e je (In yrs. last birthd	Balti (av) If Under 1 Year	More If Under 24 Hrs.	8. Date of Birth	9. Bin	tholace (State or Foreign
	Funeral Director			<b>©</b> M 2□F	60 Yrs	Months Days	Hours Min.	Sept. 1	9. Bir 1,1946	thplace (State or Foreign buntry) Maryland
	D .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	s Location				10d. Inside City Limits
	Aaryla f sho	ŏ	MD Montgor	nerv		Burtonsvi	110			1 ☐ Yes 2 ☐ No
	28a-	Director	10e. Street and Number			10f. Zip Code	110	1	0g. Citizen of What Co	
	h with	<u>a</u>	35 Crosswood	l Court			20866		U.S.A	
	r dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of H	ispanic Origin? (Si	pecify Yes or No- O Rican, etc.)	14. Race - Ame Black, Whit	
36	rs afte	y F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔯 Divorced	1 ☐ Yes 2. If Yes, Give Year or Dates;	No	1 ☐ Yes 2/2 No	Specify:		Specify: B1	ack
21215-0036	72 hours after death with the Maryland natural, or fleme 23a or 28a-f show clical Examination notified at	Completed by Funeral	15. Decedent's Ed	ucation	16a. De	ecedent's Usual Occup	ation		16b. Kind of Business	
215	within 72 ho jiene. r then "natur the Madicel	nple	(Specify only highest grain Elementary/Secondary (0-12)	College (1-4or	5+) lit	live kind of work done of the body of the	1)	king		
21		Co	9th			Self-empl		(Fine 14:44)	Labor	er
anc	d ta b	Be	17. Father's Name (First, Middle, Last)  Harold S. Do	nteon				ne (First, Middle, M therine	Spencer	
Maryland	2 should and Men is marke	2	19a. Informant's Name/Relationship (7		19b. M	ailing Address (Street				Zip Code)
	ath a		Harold Dotson	(Son)					-	,MD 20866
Baltimore,	ges 1 art of Heart If Item or othe		20a. Method of Disposition 1 □ Byrial 2 ☑ Cremation 3 □	Removal Mon State	cometon	sposition (Name of crematory or other place	e)	Date :	20c. Location - City or	Town, State
Ë			4 ☐ Fonation 5 ☐ Other (Specify	2011	Liverd	lale Park				
Bai	permit. Pag Department Important:: any injury c		21. Signature of Funeral Service Lictor	X 110		22. Name and Addre				HOME, P.A.
			23a Part1. Enter the disease, or comp	lications that cause	d the death. Do not					,MD 20850
5	Physician		23a Part I. Enter the disease, or comp shock, or heart failure Immediate Cause (Final	orfe cause on each li	1.0			,,		Interval Between Onset and Death
F 49	/Medical		disease or condition resulting in death)	a Due to (or as	a consequence of):	Cancer				months
	Examiner		Sequentially list conditions	b						
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):					
	xecut and	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
760,	n certificate be executed inding physician and use as the burial-transit	calE		d						
89	rtificat ng phy as th		TOTAL STATE OF THE	2000 - 200		40000				
Box	eath cer attendir for use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		3 Ectopic pregnancy			23d. Date of del	ivery Day Year
0	it the dea by the a tached for	Physician/Medi	1 Yes 2 No	4□Pregnant a 9□ Unknown	t time of death	5 Other (specify)		<del></del>	Worter	Day 16ai
Δ.	\$ <b>6</b> €		Part II. Other significant conditions co	ontributing to death t	out not resulting in th	e underlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
of Vital Records,	w requires been sign should be	ed by						1 □ Ye	s 2□No 3□Pr	obably 4. Onknown
၀၁	e law requ has been je 2 shoul	plet						24a. Was ar	24b. Were au	itopsy findings available completion of cause of
Œ		Completed						autops perform	ned? death?	
Vita	Physician: This certificate al director, p	Be	25. Was case referred to medical examiner?	Hospital:		I Oth		th (Check only one	9)	.1 .
		6	1 ☐ Yes 2 € No  27. Manner of Death	1 ☐ Inpation	ent 2 ER/Outpa		4 Linuising m	ome 5 Reside	-	city) Hospice
lon	Attending I or death. ector: After by the funer	tlor	1. Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Inju	ry Wor	k? Yes 2 ☐ No	252. 5555155 115	w many occurred	
Division	r Attendi er death. rector: A by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of in	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Str. City or Town	reet and Number or Ru State)	ıral Route Number,
Ö	itel or rs aft rs Di			N)						
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier , Certifying Ph. (Check only one)	iner: On the basis o	f examination and/o	eath occurred at the tin r investigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
e e	o the	Med	29b. Signature and title of certifier	and manner st	a160.	29c. License	e number	29	d. Date signed (Mont	h, Day, Year)
	V		> 5/180 W			D2	+170	N	Jovember	27 200h
	-		30. Name and address of person who		-		را حا	12 11.	ovember ove, MD z	- /,
			31. Date filed (Month, Day, Year)	chey Hosp	rar's Signature	N. Eut	aw St.	Daltin	ore, I'VY Z	1201
	Sta Registr		NOV 2 9 20	06 John	rar's Signature	ale				

06-09148 Please Type or Print in Black Indelible Ink India Dozier State of Maryland / Department of Health and Mental Hygiene 1- For Stave Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day December 1, 2006 Year 0839 hrs **Medical Examiner** India Dozier 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 7. Age (In yrs last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or **Funeral** Foreign Months Days Hours Min Director 1 M 2**X** F 21 Yrs Country) July 30,1985 Md. Ukn Usual Residence of Decedent 10a State 10c. City, Town or Location 10d Inside City Limits 10b. County or 28a-f show Washington 1 X Yes 2 No DC or items 23a or 28a-f shor must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? United States 20018 1913 Upshur Street, NEFuneral 11. Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Armed Forces? White etc. Yes 2 X No should be filed within 72 hours after and Mental Hygiene Widowed Divorced If Yes, Give Year Yes 2 X No specify Specify Black "natural", ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) it: If item 27 is marked other than "other traumatic event, the Medical MD 21215-0036 Student College 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Larry Dozier Romaine Wilson Pages I and 2 should I nent of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (2007) 19b. Mailing Address (2007) 19b. Mailing Address (2007) 19b. Mailing Address (2007) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road 501 Romaine Dozier/mother Florence SC 20b. Place of Disposition (Namé of cemetery, Resurrection: Cen. Clinton, Md. Baltimore, 20a Method of Disposition 12/11/06 1XX Burial 2 Cremation 3 Removal from State Important: I permit Page Department verdale Park Cred.12/8/06 Riverdale, Md. Donation 5 Other Specify 22. Name and Address of Facility Hodges & Edwards F.H. 21. S at le of Funeral Service License 3910 Silver Hill Rd., Suitland, Md. 20746 23 Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a Hanging Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit Physician/Medical physician a UNPENDED X AMENDED #20a-c PER FH g862 12/22/06 JH Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown Unknown as been signed by t should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of death? performed? 1 🗸 Yes After this certificate ✓ Yes 2 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other: 1 🗸 Yes ٩ 28a. Date of Injury FOUND: Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d Describe how injury occurred Certification: Subject hanged herself **FOUND** Natural Pending 1 Yes 2 ✔ No the To the Funeral Director: Dec 1, 2006 0745 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 3112 Sounding Dr, Edgewood, MD determined (Specify) Single Family Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of certifie 29c License number 29d. Date signed (Month, Day, Year) mo O.C.M.E. December 2, 2006

2

State

Registrar

Ling Li, MD

31. Date filed

DHMH 17 Rev 1/2001

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

<sup>4</sup>3" 2006

Assistant Medical Examiner

Registrar's Signature

		4	For State of Maryla		artment of F <i>rtificate of I</i>			2006	39817
(1)	Physicia	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Yea	
	/Medic Examin	al .	Marilyn Jane  4a. Facility Name (If not institution, give street and number)	Donahue		r Location of Death	1'2-(	0 - 2 000 4c. County of De	
	LAGITIM		Memorial Hospital		Cumber			Allegany	
	Funeral Director		219-14-7322 1 DM 2 KF 81	rs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) Feb 15,	1925	Birthplace (State or Foreign Country) MD
	ehow		Usual Residence of Decedent  10a. State 10b. County 10c. 6  MD Allegany	City, Town or Lo	berland				10d. Inside City Limits
	ith the Maryla or 28e-f ehov	Director	10e. Street and Number	Ouim	10f. Zip Code		100	g. Citizen of What	1 \text{ Yes 2 \text{ No}}
	th with	al Dir	415 Louisiana Avenue			21502		USA	
036	tiled within 72 hours after death with the Maryland Hygiene. ther then "natural", or ttems 23a or 28e-f ehow int, tre Medical Evantinat must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marned 3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	i	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	dispanic Origin? (Specan, Mexican, Puerto F Specify:	city Yes or No- lican, etc.)	Black, W	merican Indian, hite, etc. hite
15-0	"natur	leted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	oation during most of workin d)	9	6b. Kind of Busine	ss/Industry
212	be filed within tal Hygiene. In other than event, the bill	Completed	Elementary/Secondary (0·12) College (1-4or 5+)	homer				wn home	
and	be d d	Be	17. Father's Name (First, Middle, Last)  Harr Henry Grimm			18. Mother's Name		on Grimm	
Maryland 21215-0036	and Mental Hygi and Mental Hygi is marked other eumatic event, I	ဍ	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or Rural	Route Number,	City or Town, State	
e, K	s 1 and 2 should if Health and Mer tem 27 is marke other treumatic		James Donahue son		V. Johnson		Cumbe	eriand Oc. Location - City	MD 21502
Baltimore,	0 0 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crei carpelli Fu	osition (Name of matory or other place uneral Home	e, P.A. 1		Cresapto	
Balt	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service Licensee	22		lî funeral Ho ginia Avenue;		and MD 21	502
Æ	· · · · · · · · · · · · · · · · · · ·		23a. Part 1. Enter the disease, or complications that studed the de shock, or heart failure. List only one cause on each line.	ath. Do not en	ter the mode of dyir	ng, such as cardiac or	respiratory arres	st,	Approximate Interval Between
	Physician /Medical	9	Immediate Cause (Final disease or condition resulting in death)	y E	m bolism	)			Onset and Death
	Examiner		Ken	sequence of):	P				Soley
A.	pe tis	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	seguence of):	hide lan	pession for	01		2 rent
my	ficate be executed physicien and s the burial-transli	Examiner	that initiated events c. Due to (or as a cons	sequence of):	Died all	Washing My	elge)		
68760,	cate be chysicie the but	edical	d						
Вох	ath certinatending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No  23c. If yes, outcome of pregnant at time of the past 12 months? 4 ☐ Pregnant at time of the past 12 months?	etal death 3[	□Ectopic pregnancy □ Other (specify) _	у		23d. Date of Month	delivery Day Year
P.O.	at the d	Phys	9 Unknown	and the second		no in Book!	22a Did taha		to the cause of death?
rds,	w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions contributing to death but not to	Sapl	The	Me.	1 🗆 Yes	_/	Probably 4 Unknown
Division of Vital Records,	sicien: The law rec certilicete has bee rector, page 2 shot	Completed	gs bleeding, gest	e ula	es py	ne sterin	24a. Was an autopsy perform 1 Yes 2	ed? prior death	autopsy findings available to completion of cause of ?
Vita	icien: certifice ector, I	Be	25. Was case referred to medical examiner?		10#	26. Place of Death			
of	g Phys er this eral dir	n: To	27. Magner of Peath 28a. Date of Injury	28b. Time o		ner: 4 ☐ Nursing Hom ry at 2	ne 5 Resider 8d. Describe how		pecify)
sion	tending Feath.	catlo	2 Accident investigation		M 1	]Yes 2□No			
Divi	a after of Direct	Certification:	4 Homicide determined 28e. Place of Injury · A building, etc. (Spe	t nome, tarm, st ∍cify)	reet, factory, office		City or Town,		Rural Route Number,
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificete has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my in the property of the property one of the property one of the property of the proper	knowledge, deat	th occurred at the tinvestigation, in my	me, date and place, a opinion, death occurre	and due to the car	use(s) and manner te and place, and c	as stated. due to the cause(s)
	To the Within To the comple	Me	29b. Signature and title of certifier		29c. Licens	2:0-		d. Date signed (M	
			1 /1/(an jillag	Here on the	(Perion)	1) 19310	r	Sec 0	1h 2006
	7		30. Name and address of person who completed cause of death (			oad Cumbe	erland Mi	D 21502	
	Sta Registi		31. Date filed (Month, Day, Year) 37. Registrar's Signature 1 Registrar's Signature 2 Registrar's Sign		uli				
- 3			MPM OF O FOOD STATES						

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

14 hours

1XYes 2 ☐ No

Maryland

Black, White, etc.

None

Month

Day

Year

2006

12:53 A<sup>M</sup>

Miller, Frederick

Registrar DHMH 17 Rev 1/2001

State

Managel Hospital, 400 W. 7th St, Frederick Md 21701

			1 - For State Registrar	State of Maryla		artment of H			iene 2006	39819
			Decedent's Name (First, Middle, Las	t)				2. Date of Deat	h	3. Time of Death
	Physicia /Medic		D <b>avid</b> Allen	Evans				Nov. 27	7, 2006 Year	6:52 A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat	n	4c. County of Dea	ath
			Garrett County M			Oak]			Garre	
	Funeral Director		5. Social Security Number 6. Security Number 11 Control of Decedent 11 Control of Decedent 11 Control of Decedent 11 Control of Decedent 11 Control of Decedent 12 Control of Decedent	X M 2□ F 7. Age (in y. 44	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 20	<sup>Year)</sup> , 1962 We	rthplace (State or Foreign ountry) st Virginia
urs after death with the Maryland	Now H		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	B-1 el	ţċ	WV Grant		Gorn	nania				1 ☐ Yes 2X No
	or 28	Olre	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	3 23a	ra	P.O. Box 50				26720		USA	
	permit. Fages I and 2 should be filled within 7 c hours arise bean with the maryland Department; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Modical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify:	
	natur	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occupa	ation during most of wor	rkina	16b. Kind of Busines:	s/Industry
7	ner " " " " " " " " " " " " " " " " " " "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	0	9	0 .	
V .	Hygien Ther ti		8 17. Father's Name (First, Middle, Last)			aborer	18 Mother's Nar	ne (First, Middle, M	Construe	ction
מומ	ontal h	Be c	Arnold Scotti	e Evans			Doris			eland
<u> </u>	mari mari	10	19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Street a			, City or Town, State,	
E :	alth a		Renee Bean/ Daugh	ter	Rt. 4	, Box 151	, Keyser	, West V	irginia :	26726
ָר ב	of Herrican		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □		Place of Dispo	osition (Name of matory or other place	е)	Date	20c. Location - City o	Town, State
	ment ment and and and and and and and and and and		4 □ Donation 5 □ Other (Specify		Bayard (	Cemetery	11/	30/06	Bayard, W	V
Dallillo	Departi Departi Importi any inj		21. Signature of Europea Service (Pen	See Etm		2. Name and Address ewart Fur			Second St nd, MD 2	1550
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition resulting in death)	a Myocardia		ction				Sudden
	/Medical Examiner			Due to (or as a cons						77
		er	Sequentially list conditions, if any, leading to immediate	b. Alcoholic		myopathy				Years
1	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Alcoholic	Gastri	stritis				Months
ĵ	an an rial-tr	Exa	resulting in death) Last	sequence of):	ce of):					
, 00,	physician and s the burial-transit	Ical		d. Chronic A	lcoholi	sm				Years
0	ing pt	Med	IF FEMALE:							
O. DOX	to the nospital or Attending Frigstoner: The law requires that beart certificate be executed within the hour after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of prei 1 □ Live birth 2 □ F 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
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2	an sig	ed b	Marijuana Usag	е				1 🔀 Ye	s 2□No 3□F	robably 4 Unknown
ecords,	as bec	Completed						24a. Was ar	n 24b. Were a	utopsy findings available
֓֞֞֜֜֝֓֓֓֓֜֝֜֜֜֝֓֓֓֓֓֓֓֜֜֝֓֓֓֓֓֡֜֜֜֝֓֓֓֓֓֡֓֡֓֡֓֡	ate h page	EOC						perform	ned? death?	completion of cause of s 2 □ No
VIIAI	ertific actor,	Be (	25. Was case referred to medical examiner?			1.2		ath (Check only on		
5	this c	2	TU THS ZIND		ER/Outpatier		4 🗀 (Vul Silly 1)		nce 6 □Other (Sp	ecify)
	ding Priystolen: The la h. After this certificate has funeral director, page 2	lon	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time o Injury	Work	γat ∢? Yes 2∐No	28d. Describe how injury occurred		
DIVISION	after deati	Certification:	2   Accident				reet and Number or F o, State)	et and Number or Rural Route Number, State)		
	one nospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  1 Certifying Physics 2 Medical Exemption	ysician: To the best of my liner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	withi To the	Σ	29b. Signature and title of certifier	7		29c. License		29	9d. Date signed (Mon	
			100 Juck	www		D63	141		11/28/0	6
			30. Name and address of person who o				C	0.13	1 1/4 1	
			Dr. Marjorie Frid 31. Date filed (Month, Day, Year)	IKIN, MD 31		urth St.,	Suite 3	, Oakland	d, Marylan	d 21550
	Sta Registr		DEC 1 20		Ro A	000				

			1 - For State Registrer	State of Marylar		artment of I rtificate of			ienę	6 39820
	Physicia		Decedent's Name (First, Middle, Last)     Robert	Roy Ervin				2. Date of Deat Month Decembe	r 8, 2008	3. Time of Death 1:45 AM M
	/Medic Examin		4. For Why Marrier (Marrier Street and supplied)							
	Funeral Director		5. Social Security Number 6. Sex 172-26-6881	7. Age (In yrs. 72	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth March 1	Ŏ°ar) 1934 9.	Birthplace (State or Foreign Pennsylvania
	Maryland	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Frederick Frederick							10d. Inside City Limits 1 □ Yes 2 □ No	
	h with the 3a or 28 st be not	ai Director	10e. Street and Number 5503 Woodlyn Ro	oad	-	10f. Zip Code 21702		11	U.S.A.	t Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene.  Interpretant: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic avant, the Medical Examinar must be notified at ODEs.	by Funerai	11. Marital Status  1 □ Never Married ♣ Married  3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	- 1	Was Decedent of If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	Black, V	American Indian, White, etc. White
15-0	in 72 ho natur	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Deced (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of wo	rking	16b. Kind of Busine	ess/Industry
212	ed withi ygiene. her ther		Elementary/Secondary (0-12)	College (1-4or 5+)		ping Man	ager		Culture	Media
land	uld be fi Aental H rkad otl tic avar	To Be	17. Father's Name (First, Middle, Last)  Roy Ervin					ne (First, Middle, M Lia Hilli		
Maryland 21215-0036	nd 2 sho lith and M 27 is ma r trauma		19a. Informant's Name/Relationship (Type Mrs. Virginia M.					ral Route Number,		
Baltimore,	Pages 1 arment of Healent of Healent of Healent III item		20a. Method of Disposition  1 Burial 2XX remation 3 Rev. 4 Donation 5 Other (Specify)	amoval from State	Place of Disponent Competers, creaters the Competers, creaters the Competers of the Compete	osition (Name of matory or other pla Crematory	Dec. 9,		20c. Location - City mithsbur	
Balt	permit. Departimporti		21. Signature of Funeral Service License	MO02	255 1	Keeney da .06 East	nd Basto Church S	rd PA Fun t., Frede	eral Homerick, MD	e 21701
1	Physician and // Medical Examiner as the burial-transit	ai Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line.	End St quence of): quence of):	er the mode of dy		c or respiratory arre	ost,	Approximate Interval Between Onset and Death
P.O. Box 687	The law requires that the death certificate ste has been signed by the attending phy. page 2 should be deteched for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	ıl death 3 [	Ectopic pregnand Other (specify)	у		, 23d. Date of Month	delivery Day Year
	uires that signed b id be dete	۵	Part II. Other significant containers continuously to death but not resulting in the underlying cause given in Part I.							
Division of Vital Records,	The law requete has been page 2 shout	Completed						24a. Was ar autops perform 1 Yes 2	y prior ned? deatl	e autopsy findings available to completion of cause of h? Yes 2 X No
Zi Si	s certifi	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	ospital: 1  Inpatient 2	200	Death (Check only one)				
ion of	To the Hospital or Attending Physicien: The lav within 24 hours elter death. To the Funeral Director Atter this certificate has completely filled in by the funeral director, page 2		27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	ry at rk? ]Yes 2 □ No	ome 3AAResidence 6 Other (Specify)  28d. Describe how injury occurred					
Divis	s efter de s efter de al Directo ed in by ti	Certification:	3 Suicide 4 Homicide  Could not be determined  City or Town, State)  286. Could not be determined  City or Town, State)							r Rural Route Number,
	To the Hospital within 24 hours e To the Funeral I completely filled	edicai	29a. Certifier 1X Certifying Phys (Check only one) 2 Medical Exemin	icien: To the best of my known:  or: On the basis of examinations and manner stated.	owledge, death ation and/or in	h occurred at the t vestigation, in my	me, date and place opinion, death occu	e, and due to the ca arred at the time, da	use(s) and manne ite and place, and	r as stated. due to the cause(s)
)	To th Withir To th comp	Me	29b. Signature and title of certifier	Leven	D	29c. Licen	se number ZIGY		December	
	6		30. Name and address of person who con James S. Grissom				204. Fre	derick. M	D 21702	
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature	B)	,	-, -		

Please Type or Print in Black Indelible Ink Maryland / Department of Health and Mental Hygiene 06-09198 Andrew Friend 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ Medical Examiner Andrew Bruce Friend 4a Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death 867 Sweitzertown Road Swanton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 6. Sex **Funeral** Months Days Hours Min Director 11 217-43-3572 1**X** M 2 23, Jan. Usual Residence of Deceden 10c, City, Town or Location 10b. County 28a-f show marked other than "natural", or items 23a or 28a-f shore event, the Medical Examiner must be notified at once. should be filed within 72 hours after death with the Maryland MD Garrett Swanton Director 10e. Street and Number 10f. Zip Code 867 Sweitzertown Road 21561 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married Married Yes 2 X No If Yes, Give Year Yes 2X No specify: Widowed Divorced traumatic event, the Medical Examiner þ or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 es 1 and 2 should be filed withit of Health and Mental Hygiene Student 17. Father's Name (First, Middle, Last) Be Alfred Friend, Karen ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) important; If item 27 is Mr. Alfred Friend, Jr., Father 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Swanton Cemetery 12/07/2006 Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 21 Ν. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician llure. List only one cause on each line. /Medical a Shotgun Wound of head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical AMENDED burial -UNPENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown has been signed by the att 2 should be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ Completed 24a. Was an autopsy performed? page ✓ Yes 2 No funeral director, 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital. 1 Inpatient 2 Other<sub>4</sub> ER/Outpatient 3 DOA 2 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day Year) Dec 3, 2006 28b. Time of Injury 28c Injury at Work? 27. Manner of Death Subject shot 1545 hrs Natural Yes 2 ✔ No Pending Certificat 2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 867 Sweitzertown Road, Swanton, MD determined (Specify) Single Family 4 V Homicide 29a, Certifier 1

24 hours after death To the Funeral Director: completely filled in by the

ca

Medi

State

Registrar

DHMH 17 Rev 1/2001 OCME 2006

2006 308

Country) MD

10d. Inside City Limits

Year

Reg No. 💪 U U	0 0 0 0
2. Date of Death	3. Time of Death
Month Day Year	1615 hrs
December 3, 2006	10151115

4c. County of Death

Garrett

9. Birthplace (State or Foreign

1995

1 Yes 2 X No 10g Citizen of What Country?

United States 14. Race - American Indian, Black, White, etc.

Specify. White 6b. Kind of Business/Industry

School School 18.Mother's Name (First, Middle, Maiden Surname)

Ky1e

867 Sweitzertown Rd., Swanton, MD 21561

20c. Location - City or Town, State

Swanton, MD

Burdock-Durst Funeral Home Second St., Oakland, MD 21550

Approximate Interval Between Onset and Death

23d Date of delivery

Month Day

23e Did tobacco use contribute to the cause of death?

Yes 2 ✓ No 3 Probably 4 Unknown 24b. Were autopsy findings available

prior to completion of cause of death? 2 No 1 🗸 Yes

Nursing Home 5 Residence 6 🗸 Other: Scene

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier 29c License number 29d Date signed (Month, Day, Year)

O.C.M.E. December 4, 2006

30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. 111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner 31. Date filed (Month, Dam Year) 6 2006

32. Registrar's Signature

		1 - For State Registrar			ertificate of		d Mental Hygi	iene <sub>9. N</sub> 2. 0 0 (	39822		
	sician edical	1. Decedent's Name <i>(First, Middle,</i> Charles Edw		, Sr.			2. Date of Death Month November	Day Ye			
	miner	4a. Facility Name (If not institution, give street and number) 5789 Conover Road				4b. City, Town, or Location of Death Taneytown			4c. County of Death Carroll		
Funer Direct		261-76-3046	S. Sex 7. Ag	e (In yrs. last birthda) 58 Yrs.	Months Days		8. Date of Birth (Month, Day, May 6,		Birthplace (State or Foreign Country) aryland		
ryland		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I		Manareta	NT. TO		10d. Inside City Limits		
the Ma	Funeral Director	Maryland Carr  10e. Street and Number	.011		10f. Zip Code	Taneyto	10	Og. Citizen of What	1 ☐ Yes 2 No Country?		
seth with	eral D	5789 Conover Ro	12. Was Decedent	Ever in ILS 12	Was Dasadant of H	21787		USA	mencan Indian,		
Ours after de rai', or item	by Fun	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	Armed Forces?	No	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	(Specify Yes or No- erto Rican, etc.)	Black, W	white white		
If e, INICITY ICITIC AT A 12-10-50  8.1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene. Item 27 is marked other them "natural", or items 23s or 28s-f show other tearnatic event, the Madical Equition (1915).	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed)  College (1-4or 5	(Giv	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Mechanic				oss/Industry		
should be filed valued be filed valued be filed valued by the filed valued by the filed valued by the filed valued by the filed valued by the filed valued by the filed valued by the filed valued by the filed valued by the filed valued by the filed by the filed value	To Be Co	17. Father's Name (First, Middle, La Robert D. Ford					Name (First, Middle, M Margaret I	,			
;, WICHY and 2 shou ealth and M n 27 is man		19a. Informant's Name/Relationshi Helen E. Forque					Rural Route Number, Faneytown,				
permit. Pages 1 and Depertment of Health important: if Item 27 any injury or other 1		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 4 □ Donation 5 □ Other (Spe		20b. Place of Disp cemetery, crit South Car	osition (Name of ematory or other place roll Crema		1/29 2006	20c. Location - City Winfield			
permit. Pages Depertment of important: If I any injury or or	ouce.	21. Signature of Funeral Service Li	MO MO	1191	22. Name and Addre	ss of Facility N Street	Myers-Durb Westmins	oraw Fune ster, MD	ral Home 21157		
Physicia	an	23a. Part . Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition	omplications that caused nly one cause on each lin	the death. Do not enter.	nter the mode of dyin		liac or respiratory arre	sst,	Approximate Interval Between Onset and Death		
/Medic Examin		resulting in death)	Due to (or as	a consequence of):							
ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause Ental Insarying Cause (Disease or injury	Due to (or as	a consequence of):							
icate be executed physicien and s the burial-transit	ical Exar	that initiated events resulting in death) Last	cDue to (or as	a consequence of):							
entificate	Medic	IF FEMALE:	23c. If yes, outcome	of programmy							
the death or y the ettens for us	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						23d. Date of delivery Month Day Year		
requires that een signed be deta	ed by Pl	Part II. Other significant condition	71/	ut not resulting in the 人 4 ぃ いん	underlying cause giv	en in Part I.			e to the cause of death?  Probably 4 Onknown		
The law te hes bage 2 st	Completed						24a. Was an autopsy perform	ed? prior death	autopsy findings available to completion of cause of ? 'es 2 No		
sician: 'sertifice	o Be (	25. Was case referred to medical 26. Place of Death (Check only one)									
Jing Phy Jing Phy After this funeral d	lon: To	27. Manner of Death 1 Seatural 5 Pending 2 EH/Outpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work?						рөспу)			
I or Attending efter death. I Director: Afte din by the fune	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be	ury - At home, farm, s c. (Specify)			28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,		
Ne Hospita 1 24 hours Ne Funeral	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best caminer: On the basis of and manner sta	examination and/or it	th occurred at the tin	ne, date and pla pinion, death oc	ice, and due to the car curred at the time, da	use(s) and manner te and place, and c	as stated. lue to the cause(s)		
	W	29b. Signature and title of certifier	Sout,	in, o.	29c. Licenso	o number		d. Date signed (Mo			
4			no completed care of do	eath (Item 23a) (Type	Print) enter	St.	Westm. y	sten im	d. 21157		
	State istrar	31. Date filed (Month, Day, Year)  NOV 2	32. Regierra 9 2006	ar's Signature	boerdi						

			1- For State of Maryland / Department	artment of Health and M rtificate of Death		ene 006	39823	
	Physici		1. Decedent's Name (First, Middle, Last)  George C. Fenton		2. Date of Death Month November	Day Year	3. Time of Death 7:55 P M	
,	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	November	4c. County of Dea		
ı			1742 Dana Street	Crofton		Anne Aru	ndel	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ ▼ 2 □ F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Bir	thplace (State or Foreign ountry)	
	Director		Usual Residence of Decedent		Dec.23,19	932 Con	necticut	
	yland now		10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits	
	Mary Mary	ctor	Maryland Anne Arundel	Crofton			1 ☐ Yes 2 ☐XNo	
	ith the	Directo	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	ountry?	
	s 23a	ral	1742 Dana Street	21114		nited Sta	tes	
36	d within 72 hours after death with the Maryland plene. r then "naturel", or flems 23a or 28e-f show the Medical Exactine must be rediffed at	by Funeral	1X Never Married 2 Married 1 XYes 2 No 1955—	Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2ズNo <i>Specify:</i>	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	te, etc.	
9500-61212	2 hou	ted t	15. Decedent's Education 16a. Decedent	dent's Usual Occupation	16	b. Kind of Business	White	
212	within 72 ene. then "na	Completed	(Specify only highest grade completed) (Give	kind of work done during most of worki DO NOT use retired)	ing	J. Kind of Dusiness	modelly	
	filed wit Hygiene other the	Con	4	Officer		JS Air Fo	rce	
and	φ <del>-</del> 0 \$	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Ma.	iden Sumame)		
5	should be nd Menta marked imetic ev	4	John Calder Fenton		Travers			
Z	d 2 st th and 17 Is r			ng Address (Street and Number or Rura			Zip Code)	
ย์	Heal Heal tem 2		20a. Method of Disposition 20b. Place of Disposi	ineyard Way, Kissi		34759 c. Location - City or	Town. State	
O E	Pages ent of ht: If i			natory or other place) Veterans Cemetery				
банттоге,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 Is marked eny injury or other treumetic e once.			Name and Address of Facility Joh				
מ	Depa Impo eny ir		Thehere & Kitta 11	47 Duke of Glouces	ter StA	nnapolis	. MD 21401	
		975	23a. Part1. Strer the disease, or complication, that caused the death. Do not enter shock, or leart failure. List only one cause on each line.	er the mode of dying, such as cardiac o	r respiratory arrest.		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	remona			20 Set and Death	
	/Medical Examiner		resulting in death)  Due to (or as a considerance of):	<u> </u>				
		e.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
	uted d ansit	Examiner	Cause Circuit Underlying Cause (Disease or injury that initiated events					
Ď.	an an rial-tr		resulting in death) Last Due to (or as a consequence of):					
00/0	cate be executed physician and the burial-transit	dlcal	d					
0	entific ding p	ക	IF FEMALE:					
Š	The law requires that the death certifit to has been signed by the attending page 2 should be detached for use as	hysician/M	The past is months:	Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year	
	the d	ysic	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)				
L	s that ned b	by PI	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?	
SDLOS	w require been sig should b				1 ☐ Yes	2 100 3 □ Pro	obably 4 Unknown	
S S	law relas be	ompleted			24a. Was an autopsy		topsy findings available completion of cause of	
<u>.</u>		Con			performed	death?	2/20	
<u>g</u>	rector	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death	(Check only one)			
5	ding Phys	1: To	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				cify)	
5	nding tth. :: Afte	atlor	27. Manger of Death  1					
2	er des rector	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office 2	8f. Location (Street City or Town, St	t and Number or Ru	ral Route Number,	
5	ital ours after all Distribution	Cer						
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director.	edical	29a. Certifier  (Check only only only)  (Check only only only)  (Check only only only only only only only only	occurred at the time, date and place, a estigation, in my opinion, death occurre	and due to the cause ad at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
	To t withi To t	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	, Day, Year)	
			March Market	1016364		11/27/10	6	
	7+1		30. Name and address of person who completed cause of dealth litem 23a) (Type) F	CSTGATE RD	BUD An	MHOTA	14021401	
	Sta Registra		31. Date filed (Month, Day, Year)  NOV 2 8 200b  32. Registrar's Signature	. soll				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 6:30 **Physician** 2006 30, Alice Elizabeth Graves November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Nursing Center Leonardtown St. Mary's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F 218-76-5935 87 1919 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Leonardtown 1 ☐ Yes 2 No St. Mary's Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20650 USA 22680 Cedar Lane Court, Apt. 303 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Teresa Mary Brenner Frank Joseph Madel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Stauffer/ Daughter P.O. Box 581, Hollywood, MD 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Joseph's Cemetery Dec. 4, 2006 Morganza, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licente 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of shock, or heart failure. List mmediate Cause (Final Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Renal +all u Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: by Physician/Medical Examine The law requires that the death certificate be executed Ulceralive or Vital Records, P.O. Box 68760, attending physician as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 5 Other (specify) 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No Certification: To 24 hours after death.

e Funeral Director; After thi letely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely and manner stated. To the within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 47066 1.06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avani D. Shah, MD, 22650 Cedar Lane Court, Leonardtown, MD 20650 DEC 0 4 2006 Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For	State of Ma	arylan						ental Hy	gienę	5000	- /	00005
	=		1 - State Registrar			Cei	rtificat	e of E	Death			Reg. Né	2000		39825
	Physici	an	Decedent's Name (First, Middle, La	st)							2. Date of De. Month	ath Day	y Ye		3. Time of Death
	/Medic Examin	al	Janice Kay Garne 4a. Facility Name (If not institution, giv				4b. City,	Town, or	Location of		Decembe	-	2006 County of D		8:12 A <sup>M</sup>
			46835 Morning Dev	w Lane, Api	t. 10	1	Lex	ingto	on Pa	ırk			St. M	ary'	S
§ 1	Funeral Director		5. Social Security Number 6. \$ 534-44-3061	Sex 7. Age 1 ☐ M 2 <b>X</b> ☐ F	e (In yrs. 1	ast birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bird (Month, Da Sep. 16	y, Year)			e (State or Foreign ) ngton
			Usual Residence of Decedent  10a. State 10b. County			, Town or Lo	cation				<u>зер. то</u>	٠ ـ ـ ـ ـ ـ	747 W		Inside City Limits
	Maryla -f sho	tor	Maryland St. Ma	ry's		xingto		rk						100	1 ☐ Yes 2\☐ No
	or 288	Funeral Directo	10e. Street and Number				10f. Zip	Code				10g. Citi	izen of What	Country	?
	ath w	ra	46835 Morning Dev					0653					ted St		
	er de	nne	11. Marital Status	12. Was Decedent 6 Armed Forces?		S. 13.	Was Deced If Yes, spec	dent of His cify Cubar	spanic Ori n, Mexicar	igin? (Spe n, Puerto f	cify Yes or No Rican, etc.)	-	14. Race - A Black, W		
2	ours aft	by	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	1 M Yes 2 □ N If Yes, Give Year or Dates: ]	1964		1 🗆 Yes	2 <b>∏</b> No	Specify:				Specify: W	hite	
ה ה	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naturel" or items 23a or 28a-f show eny injury or other treumatic event, the Medical Exact for investigation and page.	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece (Give	dent's Usua kind of wo DO NOT us	rk done di	uring mos	t of workir	ng	16b. Ki	ind of Busine	ss/Indus	itry
7 7	d withi giene. er then	omp	Elementary/Secondary (0-12) 12	College (1-4or 5	i+)		les						Avon		
/alla	d oth	Be	17. Father's Name (First, Middle, Last	)					18. Mothe	ər's Name	(First, Middle,	Maiden	Sumame)		
<u>x</u>	Ment Ment Marke Marke	٦	Wayne Ashberger			1				-	ae Vine				
M	id 2 sh Ith and 27 is m treum		19a. Informant's Name/Relationship ( Russell Garner/Hi								Route Number				
ນົ	tem ?		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nan	ne of		D	ate		ocation - City		
Dalling	Pages entoi nt: If ry or		1 the Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Control of the Co			eme <i>tery, cre</i> r :yland			,	eceml) 8.		Chel	l tenha	m. M	aryland
	mit. partm porta y Inju		21. Signature of Euneral Service Line	nsee	1101		2. Name an								e, P.A.
Ď	Dermi Depa Impo eny II		Edward N. Brin	sfield, Jr.	. MOC	052 2	2955	Holly	ywood						
, F	hysician /Medical		23a. Part1. Enter the disease, or com shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	a. OWW	nan	Car	ter the mod	e of dying	g, such as	cardiac o	r respiratory ai	rest,		In	pproximate terval Between nset and Death
*	Examiner		Conversion by Net and distance	Due to (or as a	a consequ	dence or):									,
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of):									
9	be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a	a consequ	vence of):									
	te be e ysiciar e burit	calE	· · · · ·	d											
0	certificate Iding phys	Medi	IF FEMALE:												
	death e atter d for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pr Other (sp						23d. Date of Month	delivery Da	ıy Year
ŗ.	that the	/ Ph	Part II. Other significant conditions	contributing to death be	ut not rest	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	obacco u	ise contribut	e to the	cause of death?
necorus,	The law requires that the ate has been signed by the page 2 should be detached.	ed by									101	res 2	<b>3</b> No 3□	] Probabi	y 4 Unknown
) )	law ras be	Completed									24a. Was	SV	prior	to comp	findings available letion of cause of
		Con									perfo 1 ☐ Yes	rmed? 2D No	death 1 🗌 Y	n? Yes 2[	□No
AIIa	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o				
5	ding Phys	: To	1 ☐ Yes 22 No 27. Manner of Death	1 Inpatie		ER/Outpatier 28b. Time of		8c. Injury	4 🗀 190		ne 5 <b>&amp;</b> Resid			Specify)	
201	Attending F r death. ector: After by the funera	ation	1 Natural 5 Pending 2 Accident investigation	1	Year)	lnjury	М	Work	? ′es 2 🔲 I	1					
	of or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined		ury - At ho	me, farm, str	reet, factory	, office		2	8f. Location (S City or Tox			Rural R	oute Number,
2	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  1 Certifying Pf 2 Medical Example 1	hysician: To the best of miner: On the basis of and manner sta	examinal	wledge, deatl tion and/or in	h occurred vestigation	at the time, in my op	e, date an inion, dea	nd place, a th occurre	and due to the	cause(s) date and	and manner place, and	r as state due to th	ed. e cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier				290	. License	number	00		29d. Dat	e signed (M	onth, Da	y. Year)
1			> acuel	22	•			75	506	86		1	2/04	120	50
			30. Name and address of person who	1 1			Print)	Sur	Leep	SC	hhab	va, r	ni).		-/
400	wik (B)		31 Date filed (Month Day Year)	TCh KOQd	ar's Signa	tollyu	voud,	mi	20	634	2				
-	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 5	2006	a, a digna	Le A									

		•	For State Registrar	State of M	laryland / De <i>C</i>		ent of H		and Me		giene Reg. No.	UUb	398	26
ı,			1. Decedent's Name (First, Middle, Last)				5-			2. Date of Dea	ath	Vear	3. Time o	f Death
	Physicia /Medic		Inez Ethel Gouge							Month	27 <sup>Pay</sup>	2006	9:∞	Рм
	Examin	er	4a. Facility Name (If not institution, give s		7)		City, Town, or		of Death			County of Deat	h	
			Long View Nursing I  5. Social Security Number 6. Sex		ge (In yrs. last birthda		nchest		24 Hrs.	8. Date of Birt		arroll	hplace (State	or Foreign
П	Funeral Director			M 2 1 F	86 Yrs.	Mon	ths Days	Hours	Min.	(Month, Da) 12/24/1	1919	Co	yland	
	pu ,		Usual Residence of Decedent		100 000 7000	La satir							1011 110	Part & Constant
	ahov	5	10a. State 10b. County  MD Carroll		10c. City, Town or Hampstea								10d. Inside C	aty Limits 2. 2. No
	28a-f	ect	10e, Street and Number		Transpaced		Zip Code				10a. Citi:	zen of What Co		
	3a or	Funeral Director	3929 Sunset Drive				1074			1		ed State	,	
	death	nera		2. Was Deceden Armed Forces		3. Was D		ispanic Orig	gin? (Spec	ify Yes or No-		14. Race - Ame Black, Whit	rican Indian,	
36	or Its	by Fu	1 Never Married 2 Married	1 ☐ Yes 2X If Yes, Give	]No		s 2 XNo	Specify:	, 1 40110 11	110411, 010.)		Specify: Wh:		
21215-0036	within 72 hours after death with the Maryland ene. then "natural; or Itama 23e or 28e-f ahow fra Medical Exert Let rrust be rediffed at	q pa	3X Widowed 4 □ Divorced  15. Decedent's Educ	Year or Dates		redent's l	Usual Occupa	ation		1		nd of Business/		
75	nin 72 n "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(G.	ve kind o	f work done of T use retired	during most	t of working	g	100. 10	110 01 00311633	industry	
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nd	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)							(First, Middle,		•		
<u> </u>	d Men marke marke	To	Harvey Eugene Buchr 19a. Informant's Name/Relationship (Type	77	10b M	ilina Add				sworth		ner r Town, State, 2	Tin Code	
Maryland	id 2 si Ith and 27 la r fraur		Laura Ruth Glover	Siste		-							ир Соав)	
ē,	f Heal f Heal item other	i	20a. Method of Disposition		20b. Place of Dis	position	(Name of or other place	7	Da	stead,		cation - City or	Town, State	
Ë	Page net o int: If		1 XBurial 2 □ Cremation 3 □ Re  1 4 □ Donation 5 □ Other (Specify)	emoval from State	Lineboro		•		2/1/2	2006 F	inch	omo, M	erul and	į.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "natural", or Itama 23e or 28e-f ahow any injury or other traumatic event, the Medical Examination in sufficient any one.	İ	21. Signature of Funeral Service License	0	DINODOLO	22. Nam	e and Addres	s of Facility	1/			Home,		
	20529		Steven W.	Elme	M00723	Main	St.,	Hamps	tead,	MD 21	074	Tiome,		
П			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	e cause on each	ed the death. Do not line.	enter the	mode of dyin	g, such as	cardiac or	respiratory ar	rest,	1	Approxima Interval Be Onset and	tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Chron	nc 06	Tr	MI	Q_	MU	esim	1 C	M HO	4	
L	Examiner			Due to (or a	s a consequence of):									
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	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last											
8760,	icate be executed physician and s the burial-transit		resulting in death) cast	Due to (or a	s a consequence of):									
687	physics the l	dical	d						_					
Box (	eath certific attending p I for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcom							2	23d. Date of del	ivery	
	death e atte	Icla	in the past 12 months? 1 □ Yes 2 X No	4☐Pregnant			ic pregnancy (specify)					Month	Day	Year
P.O.	The law requires that the death certific ste has been signed by the attending page 2 should be detached for use as	by Physician/Me	9 □ Unknowń	9∐ Unknown										
Ś	w requires that been signed b should be det	by	Part II. Other significant conditions con	tributing to death	but not resulting in the	underlyii	ng cause give	en in Part I.			obacco u: res 2[	se contribute to		death? Unknown
Ö	been should	eted	1063001	CONTRACT										
Rec	he law e has ige 2 s	Completed								24a. Was autop perfor	rmed?	prior to death?	topsy findings completion of c	ause of
tal	en: T tificate or, pa	a	25. Was case referred to medical					26 Place	of Death	☐ 1☐ Yes (Check only o	2 No	1 ☐ Yes	2X No	
Ę.	Phyaician: The la r this certificate has and director, page 2	To B	examiner?	ospital: 1 🗆 Inpat	ient 2 ER/Outpar	ient 3	DOA Othe	- M				6 □Other (Spec	cify)	
0	ng Ph	ou:	27. Manner of Death  1 XNatural 5 ☐ Pending	28a. Date of Inj (Month, D	jury 28b. Time ay Year) Injur	/	28c. Injury Work			3d. Describe h	now injury	y occurred		
sio	tandi leath. tor: A the fu	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	00 - Disease (In		М		Yes 2□1	-	26 Lanatian (C	244		and Davids Ad	
Division of Vital Record	al or Attanding P s after death. I Diractor: After t d in by the funera	Certification:	4 Homicide determined		njury - At home, farm, etc. <i>(Specify)</i>	street, Tac	ctory, office		20	City or Tow		d Number or Ru )	irai Houte Nun	nper,
_	To the Hospital or Attanding Phwithin 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral		29a. Certifier Certifying Phys	ician: To the bes	t of my knowledge, de	ath occur	red at the tim	ne, date and	d place, ar	nd due to the o	cause(s)	and manner as	stated.	
	ne Ho n 24 h ne Fui	edical	(Check only 2 Medicet Examinone)	er: On the basis and manner s	of examination and/or	investiga	tion, in my of	oinion, deat	th occurred	d at the time, o	date and	place, and due	to the cause(s	5)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	0 ~.0			29c. License		- 5			e signed (Monti		
,	NJL		▶ Cotanysty	201100			Ŋ	511	05	2	(1	- 284	שנ	
	2		30. Name and address of person who cou	349	malo	Print)	DR	, (	Les	trin	iste	2 1	1) 7/11	57
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 2 9 2		trar's Signature	La	us s							

		·	For State Registrar	State of Maryla		artment of H rtificate of			iene <sub>eg. No.</sub> 006	39827
	Physici	an	1. Decedent's Name (First, Middle, Las	C 1	Sr.			2. Date of Dear Month	th Day Year	3. Time of Death
	/Medic Examin	i	4a. Facility Name (If not institution, give				Pr Location of Dea		4c. County of Death	1
	Funeral Director		5. Social Security Number 6. Se X 493-34-4980 Usual Residence of Decedent	x 7. Age (In yrs	. last birthday) Yrs,	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. Births 4, 1934	place (State or Foreign ntry) Missouri
	within 72 hours after death with the Maryland ane. then "naturel", or Items 23e or 28e-f show he Medical Examatur must be notified at	Funeral Director	10a. State 10b. County  MD Carr		West	minster				10d. Inside City Limits 1 ☐ Yes 2 No
	with the	Dire	10e. Street and Number	'11 m 1		10f. Zip Code		1	log. Citizen of What Cou	ntry?
	eath ris 23	era	1238 Fringer M	111 Rd.  12. Was Decedent Ever in 1	U.S. 13	Was Decedent of h		Specify Yes or No-	USA 14. Race - Americ	can Indian
920	ges 1 and 2 should be filed within 72 hours after death with the Maryla It of Health and Mental Hygiene. If Item 27 is marked other than "naturel", or items 23a or 28a-f show or other traumatic event, the Medical Exptr for market couldied at	by Fun	1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1X Yes 2 □ No 1 9	954	If Yes, specify Cub 1 ☐ Yes <b>X</b> XNo	an, Mexican, Pue	rto Rican, etc.)	Black, White,	
21215-0036	within 72 h	Completed by	15. Decedent's Ed (Specify only highest gran	college (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	orking	16b. Kind of Business/In Baltimo	re
	Hygie Hygie other		17. Father's Name (First, Middle, Last)		⊥Supe	rvisor/		ortation me (First, Middle, I		lectric
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Tre Ma	To Be	Ralph Bennett		19b. Maili	ng Address (Street			zabeth Wy	
	and 2 salth ar n 27 is		Victoria Meckel	Daughter		Middle			n Bridge,	
Baltimore,	permit. Pages 1 and i Department of Health Importent: If Item 27 any injury or other tr once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cre	osition (Name of matory or other pla Cremat	' I		20c. Location - City or To	
Balti	permit. Pa Departmen Importent: any injury once.		21. Signature of Funeral Service Ligen		2	2. Name and Addre	ess of Facility Pri	tts Fun	eral Home	& Chapel
	Physician		23. Part1. Enter the disease room, nock, or heart failure. List only immediate Cause (Final disease or condition	lications that caused the dear cause on each line.	ath. Do not en		ng, such as cardia	ac or respiratory arr		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse						f
	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conse	equence of):					
8760,	cate be executed obysician and the burial-transit	dicai Exar	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
.O. Box 68	ath certification of use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1   Live birth   2   Fe 4   Pregnant at time of 9   Unknown	tal death 3[	⊒Ectopic pregnanc ⊒ Other (s <i>pecify</i> ) _	у		23d. Date of delive	ery Day Year
٥	es that gned b		Part II. Other significant conditions co	ontributing to death but not re	esulting in the u	ınderlying cause gr	ven in Part I.	23e. Did tol	bacco use contribute to t	he cause of death? pably 4 DUnknown
I Records,	e law has b	Completed						24a. Was a autops perfori	sy prior to co	opsy findings available impletion of cause of
Vital	ysicien: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?					eath (Check only on		
of \	hys this	2	1 ☐ Yes 2 ☐ No		ER/Outpatie	III 3 DOA			ence 6 Other (Special	(y)
on	ding After funer	tion	27. Manne of Death  1	28a. Date of Injury (Month, Day Year)	Injury	Wo	ryat rk? ]Yes 2 ⊟No	280. Describe no	ow injury occurred	
Division	ten leat tor: the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		home, farm, st			28f. Location (Si City or Town	treet and Number or Run n, State)	al Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	ledical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best of my kr liner: On the basis of examin and manner stated.	nowledge, dear nation and/or in	th occurred at the tinvestigation, in my	ime, date and plac opinion, death occ	ce, and due to the courred at the time, d	ause(s) and manner as s late and place, and due t	stated. o the cause(s)
	To th Withir To th Comp	M	29b. Signature and title of certifier	2.644 0		29c. Licen:		2	29d. Date signed (Month,	Day, Year)
	111			Mighel 1	<b>~</b>	1000	59943		Mormiser	27,2000
	WIL		John ( Assermo	completed cause of death (lite	er Ar	Print)	2 307	nesn	ninster Ma	0 21157
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  NOV 2.8	32. Registrar's Sign		house .				

State of Maryland / Department of Health and Mental Hygien 👂 🕦 39828 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Colleen Martha Gormley November 27, 2006 10:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Health & Rehab. Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day, Year) | 1973 5. Social Security Number **Funeral**  Birthplace (State or Foreign Country) 215-02-6566 Director Maryland Usual Residence of Decedent with the Maryland 10b. County itsm 27 is marked other then "natural", or Items 23s or 28e-f show other traumatic event, the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3123 Fairweather Court 20832 USA death v Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other then "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Occupational Therapist Medical 17. Father's Name (First, Middle, Last) Be ( 18. Mother's Name (First, Middle, Maiden Sumame) Richard Charles Steffan Jeanne Mae Painter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael A. Gormley/ Husband 3123 Fairweather Court, Olney, Maryland 20832 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Peges
Department of
Important: If it
eny injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Dec. 4, 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 2006 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 500 University Blvd, West, Silver Spring, MD 2090 Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) BRAIN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 2.2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 1□ Yes 2 No To the Hospital or Attending Physician: ours after death.

neret Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending 1 Natural Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Basino 00057124 11/28/06 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive, #201, Rockville, MD 20850 Truong Bao, M.D. 31. Date filed (Month Year) Registrar's Signature State 2006 Registrar

		For State Registrar	State of	Maryland / D		ment of H icate of I		d Mental H	ygiene Reg. No.	2006	39829
Physicia	an	Decedent's Name (First, Midd		nhu				2. Date of D Month	eath Day	Year	3. Time of Death
/Medic		4a. Facility Name (If not institution	Louise Gu		45	. City, Town, or	Location of D	Novem		30 200 County of Death	6 4:15A M
Examin	er	Atlantic Gen		•	40	Berlin		adin .		Worceste	r
Funeral		5. Social Security Number	+	. Age (In yrs. last birt	thday) If	Under 1 Year	If Under 24 h		irth	. ,	place (State or Foreign
Director		207-12-5313	1 M 24 F	95	Yrs. M	onths Days	Hours M	in. (Month, E March	Day, Year)	Coui	vland
<b>D</b>	Ì	Usual Residence of Decedent						I-ELL-CI1	12, 131	TIGI	yrana
72 hours efter death with the Maryland natural; or Iteme 23a or 28e-f ehow dical Exercities must be cotified at		10a. State 10b. Count	у	10c. City, Town	n or Location	on				1	0d. Inside City Limits
e Ma	cto	MD Wor	cester	Ber	lin						1 ØYes 2 □ No
or 2	Dire	10e. Street and Number			1	Of. Zip Code			10g. Citiz	en of What Cour	ntry?
ath w	Funeral Director	508 Bay Stre				21811				USA	
er de	nue	11. Marital Status	Armed Ford		13. Was	Decedent of Hi s, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	io- 1	<ol> <li>Race - Americ Black, White,</li> </ol>	
S of	by F	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give		10	Yes 2⊠ No	Specify:			Specify: Bla	ick
hour	Pe		d Year or Dat		Decedent	a Haval Occupa	**		101 10	4-40	
in 72	Completed	(Specify only highe	est grade completed)		(Give kind	s Usual Occupa of work done o VOT use retired	furing most of i	working	160. Kin	d of Business/In	dustry
filed within Hygiene. Ither then "I out, the Mes	E	Elementary/Secondary (0-12) 9th	College (1-4	for 5+)		Labore			Hom	emaker	
Hygin Hygin ent.		17. Father's Name (First, Middle	, Last)			Habores		Name (First, Middl			
ould be Mental Marked o	To Be	John Fassett					Sara	h Robbin	S		
d 2 should be lifed within 72 hours efter death with the Marylan thand Mental Hygiene. I had Mental Hygiene. I have standard other then "natural; or iteme 23a or 28e-f ehow treumatic event, the Medical Examinational be notified at	-	19a. Informant's Name/Relation	ship (Type, Print)	19b.	. Mailing A	idress (Street a	and Number or	Rural Route Num	ber, City or	Town, State, Zin	(Code)
nd 2		Carolyn Fass	ett/Niece					lin, Mar			,
te Hei		20a. Method of Disposition		20b. Place of	Dispositio	(Name of	a)	Date	20c. Loc	cation - City or To	wn, State
Pages nent of I ant: If It ury or o	ı	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		ate	_	ry`or other place Comotersz		. 5 <b>,</b> 2006	Ber	clin, Ma	rvland
교원관중 .	1	21. Signature of Funeral Service		St. Pau		Cemetery me and Addres				Road 2190	
Depe Impo eny Ir		Linosta	BUX	1000				hapel -			
		23a. Part1. Enter the disease, o	r complications that cau	used the death. Do n		-					Approximate
Observation :		Immediate Cause (Final	t only one∡cause on ead	ch line/						ĮI,	Onset and Death
Physician /Medical		disease or condition resulting in death)	a Duo to (or	000000	ce	110	vac	4		1 1	Vay 5
Examiner			An	as a consequence of	<del>/-</del>	Carlon	1	on Di			70.0
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequence of	of):		Varou	cur por-		-	200,5
cate be executed physicien and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b> .								
exection and and and and and and and and and an	EX	resulting in death) Last	Due to (or	r as a consequence of	of):						
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g ph as th	ed		1	90							-
e ettending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy	ء ⊏ح۔				2:	3d. Date of delive	ory
the ette	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnar	h 2 Fetel death nt at time of death		opic pregnancy er (specity)				Month	Day Year
by the	hys	9 □ Unknown	9□ Unknow	m 							
pe de	by P	Part II. Other significant conditi	ions contributing to dea	th but not resulting in	the under	ying cause give	n in Part I.	23e. Did	tobacco us	e contribute to the	ne cause of death?
been si								_ 1 🗆	Yes 2	No 3□ Prob	ably 4 Thinknown
as been 2 shoul	Completed							24a. Wa		24b. Were auto	psy findings available impletion of cause of
ete has been signed by th page 2 should be detache	E							perl	omed3	death?	
	4	25. Was case referred to medica	al .				26 Place of F	1 ☐ Yes Death (Check only	2 500	1 🗆 Yes	2L/No
0 =	0	examiner?	Hospital: 1 ☐ Inc	patient 2 ER/Out	tnatient 3	□ DOA Othe	•	Home 5□Res		Other (Secret	al.
er th	=	27. Manner of Death	28a. Date of	Injury 28b. T	Time of	28c. Injury Work	at	28d. Describe			<u>//</u>
r death. octor: After by the funer	tio	1 <del>SNat</del> ural 5 ☐ Pendi 2 ☐ Accident invest	ng (Month, igation	Day Year) Ir	njury P		? ′es 2 ☐ No				
after deatl Director: In by the	Certification:	3 ☐ Suicide 6 ☐ Could	nined 286. Place of	f Injury - At home, far	rm, street,	actory, office		28f. Location	(Street and	Number or Rura	l Route Number,
d in b	ert	4 Homicide determ	building	, etc. (Specify)				City or To	wn, State)		
nere y fille		29a. Certifier Certifyi	ng Physicien: To the b	est of my knowledge	, death occ	urred at the tim	e, date and pla	ice, and due to the	cause(s) a	and manner as st	ated.
within 24 hours after To the Funerel Dir completely filled in	Medical	(Check only 2 Medical one)	Exeminer: On the bas and manne	is of examination and	d/or investi	gation, in my op	inion, death oc	curred at the time	, date and	place, and due to	the cause(s)
withir To th	ž	29b. Signature and title of certific	ər			29c. License	number		29d. Date	signed (Month, i	Day, Year)
		M/ 179511	ul 1			D2	816	9	1-	2 lilo	5
4		19. Name and address of person	who completed cause	of death (Item 23a) (	Type Print			1			5 LDC 1994
7		Nichola, Bo	roleile. 1	D 12-7	9/	castel	Hz.1.	in Ke	. Act	Fel. 1	N laoin
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Stat	е	31. Date filed (Month, Day, Year, DEC 1 3	. Rec	gistrar's Signature	1	0 - 0 - 1	9	-/-		7000	PC 110-4-

06-09209 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Maurice Harrison 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Time of Death Month Day December 3, 2006 **Medical Examiner** 2219 hrs MAURICE S. HARRISON, SR. 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Harford Havre de Grace 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 12/18/1964 Country) MARYLAND 41 218-72-3224 1X M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits HAVRE DE GRACE HARFORD 1 X Yes 2 No MARYLAND hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? USA 567 GIRARD STREET 21078 Funeral 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 1 X Yes If Yes, Give Year UNKNOWN Specify: BLACK Widowed Divorced 1 Yes 2 X No specify: ۾ 16a. Decedent's Usual Dccupation (Give kind of work done 15 Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 MD 21215-0036 event, the Medical RESTAURANT COOK 12 J Mental Hygiene s marked other th 17 Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be DIANE BROWN MICHAEL HARRISON, SR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and I Important: If item 27 is r injury or other traumatie 887 RANDALL DRIVE, ABINGDON, MARYLAND 21009 MICHAEL HARRISON, SR FATHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State BERKLEY CEMETERY 12/12/06 DARLINGTON, MARYLAND Donation 5 Other Specify 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GRACE 21 Signature of Funeral Service Licensee -colem MD 21078 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Cardiac arrythmia due to disseminated sarcoidosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and hysician/Medical X UNPENDED AMENDED 23a,27,perME, g863, 1/2/07 TT requires that the death certificate be P.O. Box 68760, 23c. If ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 Yes 28a. Date of Injury (Month, Day, Year) 28b Time of Injury 27. Manner of Death 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) within 24 hours a To the Funeral (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 4, 2006 30. Name and address of person who completed cause of death (Item 23a)

State Registrar

DHMH 17 Rev 1/2001

Ana Rubio MD.

31. Date filed (Month, Day, Year,

DEC 1. 1 2006

Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

			1 - For State Registrar	State of Ma	ryland /				ealth a Death	and M		giene Reg. No.?	106	39831
	Physici	an	Decedent's Name (First, Middle, Last								2. Date of Dea		2ŎO'6	3. Time of Death 1:05 P M
	/Medic	al	Lorraine Yvonne  4a. Facility Name (If not institution, give	Hampton			4h Cin	Tour or	Location o	f Dooth	Novemb		ZUU0	1:03 F M
	Examin	ier	Washington Advent:		a1			ma Pa		Dealli		1	gomery	
Ī	Funeral Director		5. Social Security Number 6. Security Number 11.	7. Age	(In yrs. last	birthday) Yrs.	If Unde Months	r 1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Birt Month, Da Feb 20	h y. Year) 1945	9. Birthp Cour Scot	place (State or Foreign nty) Land
	w.		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	ocation						1	10d. Inside City Limits
	Maryl	to	Maryland Montgomen	cy s	Silver	Spr	ing							1 ☐ Yes 2 🙀 No
	h with the 23e or 28e	Funeral Director	10e. Street and Number 11200 Lockwood Dr:	ive #614				р Code 901				10g. Citizen o USA	f What Cour	ntry?
36	vinitin 72 hours after death with the Maryland liene. I then "neturel", or Items 23a or 28a-f ehow Ita Mazical Examinar must be notified at	by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Example Forces?  1 Yes 2 No. If Yes, Give Year or Dates:	ver in U.S.		Was Dece If Yes, spe 1  Yes		spanic Origin, Mexican Specify:	gin? (Spe n, Pu <i>e</i> rto I	cify Yes or No Rican, etc.)		ace - Americ lack, White, hite	etc.
21215-0036	72 hou	eted	15. Decedent's Edi (Specify only highest grad	ucation de completed)	1	6a. Dece	dent's Usi	al Occupa	ntion Juring most	t of workii	na	16b. Kind of	Business/Inc	dustry
121	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	) Δ.	life.	DO NOT I	ise retired	Assis			Federal	Gove	rnment
2			17. Father's Name (First, Middle, Last)		ric	*111.1.1.1	Stra	LIVE			(First, Middle,			
/lan	d 2 should be file th end Mental Hyg 7 le marked othe traumatic event,	To Be	Thomas Hughes Cutl	nbert					Jane	Rol1	and			
Maryland			19a. Informant's Name/Relationship (T. James Hampton/son	ype, Print)			121				Hickor			Code)
	es 1 an of Heel f Item 2 r other		20a. Method of Disposition  1 □ Burial 24 Cremation 3 □	Daniel Chata	20b. Place ceme						ate	20c. Location		own, State
Baltimore,	mit. Pages partment of cortant: If It Injury or o		4 □ Donation 5 □ Other (Specify	)	Chesa	apeak	e Cr	emato	ry 1			Beltsvi		
Bal	permit. Page Dapartment of Important: If eny Injury or page.		21. Signature of Funeral Service Licens	Latte	MO12	Go 251 <sub>Be</sub>	Name a ing ver1	nd Addres Home y L.	s of Facilit Crema Heckr	atior cotte	Servi	ce P.C Clarks	. Box	784 MD 21029
	Physician		23a. Part1. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	olications that caused to one cause on each line	he death. [	Do not ent	ter the mo	de of dying	g, such as	cardiac o	r respiratory a	rrest,	15	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Drayo (or as a	consequen	ice of):	+7		5	o S:	25			
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o,	be executed sicien and burial-transit	Examine	that initiated events resulting in death) Last	c. Pue to (or as a	consequen	ice of):	1	- A-	<i>-</i> -	17			_	
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.O. Box (	at the death certificate be executed by the attending physicien and tached for use es the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 0 No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal de	ath 3[	∃Ectopic p ∃Other (s			431 ST			Date of delive Month	ery Day Year
rds, P	es the	þ	Part II. Other significant conditions co	ontributing to death but	not resultin	ng in the u	inderlying	cause give	en in Part I.			obacco use co ∕es 2 □ No	ntribute to th	he cause of death?
Records,	The law requir ate has been s page 2 should	Completed										rmed?	prior to con death?	ppsy findings available impletion of cause of
Vital		BeC	25. Was case referred to medical examiner?		/				26. Place	of Death	1 ☐ Yes	2 No	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20,000
of V	Physicien: this certific rat director,	To E	1 Yes 2 No	Hospital: atien		/Outpatier			4 🗀 140		n <i>e</i> 5□Resid			y)
ono	ding h. After fune	tlon:	27. Manner eath  1 tural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28	lb. Time o Injury	f M	28c. Injun Work	rat ⊲? Yes 2.∐.I		28d. Describe I	now injury occi	urred	
Division	l or Attenderter deatl Olrector: Jin by the	Certification:	3 Suicide 6 Could not be determined		y - At home (Specify)	, farm, st	reet, facto	ry, office		4	28f. Location (S City or Tox		nber or Rura	al Route Number,
	To the Hospital or within 24 hours effer To the Funerel Director Completely filled in b	edical C	29a. Certifier (Check only 2 Medical Examone)	ysicien: To the best of iner: On the basis of and manner stat	examination	dge, deat and/or in	h occurred vestigatio	d at the tim	e, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) and r date and place	manner as si	lated. the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier				29	c. License	number	~ ~	_	29d. Date sign	ned (Month)	Day, Year)
	_		2/1/1					1	01.	20	t	111:	50/0	06
6	100		30 Name and address of person who	completed cause of de	ath (Item 23	(Type,	Print)	76	124	CA In	of P	Mu	Mi	) 209 (S
	Sta Registi		31. Date filed (Month, Day, Year)  DEC 0 1 2	32. Begistra	's Signature	4	Par W						1	

State of Maryland / Department of Health and Mental Hygiene? 39832 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Dec. 4, 1:55 PM Virgie Virginia Hanlin 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cuppett-Weeks Nursing Home 0akland Garrett If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. (Month, Day, Year)
Mar. 7, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2X F 87 Yrs. Director 235-52-5392 1919 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits nd other than "naturel", or iteme 23a or 28a-f ehow event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo MD Garrett Oakland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8712 George Washington Highway 21550 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. e filed within 72 hours efter all Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 N Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked othe eny lighty or other traumatic event, PARS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Wayman Kitzmiller Cora ೭ Almira Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Kuhn/ Son 8712 George Washington Highway, Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Slate 4 Donation 5 Other (Specify) Mount Storm Cemetery 12/8/06 Mount Storm, West VA 21. Signature of Funeral Service Licens 22. Name and Address of Facility 32 S. Second St. Stewart Funeral Home Oakland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pheumonia doug /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ettending physicien and for use as the burial-translt certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cordioriseylor 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an senile ouse 1 Yes 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? al or Attending P sefter death. It Director: After 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide To the Hoepital within 24 hours a To the Funeral Completely filted the Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 00025759 30. Name and address of person who completed cause of death, (Item 23a) (Type, Print) POBOXZ47. Accident MD21520 Walter K. Naumann MD 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARTHA ELIZABETH HARBAUGH November 28, 2006 9:50 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Catherines Nursing Home Emmitsburg Frederick 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 □ F Months 220-18-1378 82 Mary land Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland Hygiene 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Maryland Frederick Emmitsburg 1 Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 331 South Seton Avenue 21727 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ☐Yes 2 No fYes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify ģ Specify: 3 X Widowed 4 Divorced White Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fill of Health and Mental H filem 27 is marked oth Be Keifer Green Adeline Draper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David W. Harbaugh / Son 7302 Kelly Store Road, Thurmont, Maryland 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Depertment of H
Important: If ites
any injury or oth Ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Creagerstown Cemetery 12/2/06 Creagerstown, Maryland 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN ST., THURMONT, MD 21788 23a. Part Lenter the dia set, of complication of Feart failure. List only one Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Priset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) mer /Medical Que to (or as a cons squence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown δ been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part In 23e. Did tobacco use contribute to the cause of death? Completed by 2 XNo 1 🔲 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 25 certificate 1 ☐ Yes or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowled je, death occurred at the time, date and place, and due to the cause(s) and manner is statled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier 29b. Signature and title of dertities 29c. License number 29d. Date signed (Month, Day, Year) 18

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Alan Carroll, MD

31. Date filed (Month, Day, Year)

DEC 0 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

32. Russtrar's Signature

310 South Seton Avenue, Emmitsburg, Maryland 21727

			1 - For State Registrar		f Maryland		artmen rtificat			and M		Reg. No.	200	6 3	
	Physici /Medic	cal	Decedent's Name (First, Middle Lena     La. Facility Name (If not institution	L.	Hancock		Ab Cibe	Town	I anation of	d Dank	2. Date of De Month November	P Z	7,00	706 O	me of Death 738 M
	Examin Funeral	ner	Peninsula Rea 5. Social Security Number	ional Med	lical Cen			Sa.	If Under	ry	8. Date of Bir	th L	County of D  i car  9.1	nico Birthplace /S	itate or Foreign
0	Director		214-10-7129  Usual Residence of Decedent  10a. State 10b. County	1□M 2 <b>X</b> ]F	90	Yrs.		Days	Hours	Min.	4/23719	916"	V	irgini	a ide City Limits
h the Mary	or 28a-f eho	irector		omico		alisb		Code				10g. Citiz	en of What	1 🔀	Yes 2 No
U Z I Z I 3-0036 filed within 72 hours efter deeth with the Maryland	Department of Heelth and Mental Hygiene. Important: or Items 23a or 28a-1 show important: If item 27 is marked other than "naturel", or Items 23a or 28a-1 show eny injury or other traumatic event, the Madigal Examinat must be notified at once.	by Funeral Director	6133 Steve St  11. Marital Status  1 Never Married 2 Marr  3 Widowed 4 Divorced	12. Was Dece Armed For 1 Yes	2 K No					gin? (Spi i, Puerto	ecify Yes or No Rican, etc.)	)- 1	Black, W	merican Indi hite, etc. white	an,
within 72 hou	one. than "nature oe Medical E	Completed	(Specify only highes Elementary/Secondary (0-12)	t's Education		(Give life.	dent's Usua kind of wo DO NOT us	rk doné d se retired,	tion uring most	t of work	ing		nd of Busine	ss/Industry	
	Mental Hygie irked other t itic event, to	To Be Co	11 17. Father's Name (First, Middle, Clarence Wise			Ket	ail S	ares			e (First, Middle) ustis		thing Surmarne)		<del>.</del>
s, INICAL y	leeth and h m 27 is ma her trauma		19a. Informant's Name/Relations Judith Renshaw,		age Bu	289	939 M	t. Ve	ernon	Rd.	, Princ	ess	Anne,	MD 21	853
mit. Pages 1	partment of H sortant: If ite / injury or ot		20a. Method of Disposition  1 □ Burial 2 ②Cremation  4 □ Donation 5 □ Other (S)  21. Signators of Funeral Service	(pecity)		ace of Disponentery, creating the second sec	ry Cre	emato	ory	12/1	/06 Home Pr	Sal	isbur		
E	physicien and Medical the burial-transit	edicai Examiner	23a. Pap. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	or as a consequence or as	ence of):	ter the mod	e of dying	such as	cardiac d	or respiratory a	rrest,		Interv	ximate al Between and Death
the death certifi	been signed by the ettending pt should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live bi	come of pregnan irth 2 ☐ Fetal o ant at time of dea own	death 3	⊒Ectopic pr ⊒ Other (sp					2	3d. Date of Month	delivery Day	Year
w requires that	een signed b hould be deta	by	Part II. Other significant condition	ons contributing to de	eath but not resul	iting in the u	nderlying c	ause give	n in Part I.			obacco us		to the caus	e of death?
an: The law	s certificate hes b director, page 2 s	e Completed	25. Was case referred to medical								1 Yes	osy rmed? 2 <b>22</b> No	prior death	to completio	dings available n of cause of
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed.	within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To B	examiner?  1  Yes 2 No  27. Manner of Death 1  Autural 5  Pendin 2  Accident investit 3  Suicide 6  Could determ	Hospital: 1 Ir Ir 28a. Date of (Month)  agation not be 28a. Place		ER/Outpatier 28b. Time o Injury me, farm, str	f 2	8c. Injury Work 1 🗆 Y	r. 4 □ Nu	rsing Ho	me 5 Residence R	dence 6	occurred		Number,
To the Hospite	within 24 hours To the Funeral completely filled	Medical C	29a. Certifier (Check only one) 1 Certifyin (Check only one) 2 Medical 29b. Signature and title of certifie	ng Physicien: To the Examiner: On the ba and mann	isis of examinationer stated.	vledge, deat on and/or in	vestigation	, in my op c. License	number	th occurr	and due to the ed at the time,	date and 29d. Date	place, and o	onth, Day, Yo	
(0	202		30. Name and address of person	who completed cause	e of death (Item :	23a) (Type,	Print)		6069	•	TausBr		11.29 ND ^	OL	u.
×	Sta Registr		31. Date filed (Month, Day, Year)	32. Re	egistrar's Signatu		6 70								T

State of Maryland / Department of Health and Mental Hygiens, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CLIFFORD **JAMES** HERRON NOV. 6:15p M 21 2006 /Medical 4a. Facility Name (If not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Brighton Gardens Assisted Living Columbia Howard 8. Date of Birth (Month, Day, Ye. Jan. 28, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Year) 1⊠M 2□F Days Hours 441-42-0410 64 Director 1942 Oklahoma Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show injury or other traumatic event, the Medical Examinar must be notified at Director 1 X Yes 2 □ No Prince Georges Laurel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9007A Contee Rd 20708-2101 or itama 23a USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1967— 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. I have 21's marked other than "natural", or flar any injury or other traumatic event the second secon Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€XNo Specify: Specify: 3 ☐ Widowed 4 X Divorced **Black** 1969 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager USDA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Herron Elizabeth Morris ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Herron/Daughter P.O. Box 232 Jessup, MD. 20794 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 11-29-2006 Maryland Veterans Cheltenham, MD. 21. Signature of Foneral Service Licenses 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, DC 20011 23a. Part1. Ender the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Multiple Myeloma 1 year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 2 signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a Wasan 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2√√No autopsy performed? 1 Yes 2CXNo 2**X**XNo To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other 4 Nursing Home 5 Residence 6 DOther (Specify) Living 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury after death.

I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funarai ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified M.D. V56531 Nov. 22, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Snowden River Pkwy Ste 301 Columbia, MD 21045 Harry Li, M.D. 31. Date filed (Month, Day, Year) NOV 2 8 2006 32. Registrar's Signature Registrar

			1 - State of Maryland		artment of H tificate of L		, ,	giene leg. N <u>2</u> 0 0 6	39836
	Physicia		Decedent's Name (First, Middle, Last)     JIN CHUL HWANG				2. Date of Dea Month NOV 27	th Day 06 Year	3. Time of Death 5:30A M
*	/Medic Examin		4a. Facility Name (If not institution, give street and number) MANOR CARE BETHESDA		4b. City, Town, or BETHEST		eath	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. In 1974) 7. Age (In yrs. In yrs. In 1974) 7. Age (In yrs. In 1974) 7. Age (In yrs. In yrs. In 1974) 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	Hrs. 8. Date of Birth (Month, Day NOV 28		nplace (State or Foreign untry) )REA
	aryland show		,	, Town or Lo					10d. Inside City Limits 1 X es 2 No
	ith the Ma or 28a-f	Director	10e. Street and Number	HESDA	10f. Zip Code 20814			10g. Citizen of What Co USA	
(0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than *natural', or items 23a or 28a-f show any injury or other traumatic event. The Medical Evaluation triant to chillian and once.	Funeral	11. Marital Status  1 Never Married 2 Married 1   Yes 2   No   Yes 2			ispanic Origin' n, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, White	e, etc.
Maryland 21215-0036	natural, c	leted by	3 Widowed 4 Divorced IT Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa	during most of	working	Specify: AS	
212	filed withir Hygiene. othar than ant, the Ma	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  1 2 4		ACHER	·		PRIVATE	
land	Ald be fill Aental Hy rked oth tic evan	To Be	17. Father's Name (First, Middle, Last)  KEIM YOMAY HWANG		-	18. Mother's	PANYEUB	Maiden Sumame)	
Mary	d 2 should th and Men 7 Is marke traumatic		19a. Informant's Name/Relationship (Type, Print) SUNG JA HWANG/WIFE		ng Address (Street a			r, City or Town, State, Z BETHESDA	
Baltimore,	Pages 1 and nent of Health int: If item 27 iry or other ti		20a. Method of Disposition 20b. Pl	ace of Dispo	esition (Name of matory or other place  MEMORIA	(e)	Date 1/29/06	20c. Location - City or	Town, State
Baltir	permit. F Departme Importar any injur		21. Signature of Fund A Service-Licensee					INDS FUNE	
	Pnysician	E V	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	3		_	rdiac or respiratory and		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequ	ence of):					
	cuted id	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ence of):					
8760,	icate be executed physician and s the burial-transit	Ical Exa	resulting in death) Last  Due to (or as a consequence of the consequen	ence of):					
O. Box 68	death certif le attending le for use a	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy			23d. Date of deli Month	ivery Day Year
rds, P	sign sign d be	þ	Part II. Other significant conditions contributing to death but not resu	lting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute to es 2 No 3 □ Pre	
Il Records,	The ate h page	Completed					24a. Was autop perfor 1 Tyes	sy prior to d	topsy findings available completion of cause of
Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examinar?  1   Yes 2   No   Hospital: 1   Inpatient 2	ER/Outpatier	nt 3 DOA Oth	90	Death (Check only only only only only only only only	ne) ence 6 ⊡Other (Spec	city)
ion of	ding h. After fune	ertification: T	27. Manner of Death  1 SNatural 5 Pending (Month, Day Year) 2 Accident investigation	28b. Time of Injury	Wor	y at k? Yes 2 □ No		ow injury occurred	
Division	r e e	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	reet, factory, office		28f. Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,
	24 h	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my know and manner stated.  Medical Examiner: On the basis of examinating and manner stated.						
)	To the vithin 2	Me	29b. Signature and title of certifier		29c. Licens		1280	29d. Date signed (Montl	
	0		30. Name and address from who completed cause of death (it)				DD 555		20050
	Sta Regist		ANUSHIRAVAN DADGAR, D.O. 97 31. Date filed (Month, Dey, Year) 32. Registrar's Signa NOV 2 9 2006	ture	EDICAL (	ENTER	R DR ROCK	VILLE MD	20850
	3	- 4	housened in tale						

State of Maryland / Department of Health and Mental Hygiene 39837 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Churchill P. Hart 6:06 PM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Medica ivista onter 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days 1 **3**M 2 ☐ F Months Hours Min 217-24-8936 Director April 6,1929 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County r than "natural", or items 23a or 28a-f show the Medical Examiner πust be notifled at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Charles Nanjemoy 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2855 Liverpool Point Road 20662 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 🗌 No 5-0036 1 ☐ Yes 🎾 No Specify þ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance Foreman U.S. Government 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be 1 ealth and Mental Joseph Hart ပ္ Mammie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Wife Mary F. Hart 2855 Liverpool Point Rd., Nanjemoy, Md. 20662 Baltimore, If item 20b. Place of Disposition (Name of cemetery, crematory or other place)
Nov. 28,2006
Maryland Veterans Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ment of h Department of Important: If it any Injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 22. Name and Address of Facility Williams Funeral Home, P.A. 21. Signature of Funeral Service Lice M00668 4270 Hawthorne Rd., Indian Head, Md. 23a. Part1. Enter the disease shock, or he intifure. Immediate Cause di nal disease or condition resulting in death) lease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIAC Physician mirms /Medical Due to (or as a consequence of): Examiner monto CARDION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed DIJEASE physician and s the burial-trans CORONA Due to (or as a consequence of): Box 68760, Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 ☐ Other (specify) signed by the a P.0. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an cate has performed: certificate 1□ Yes or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 📆 🗘 o 1 npatient Medical Certification: To 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Aatural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No death. within 24 hours after death **To the Funeral Director**: . сотрletely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) cw 2006 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) Pa BHE 5. 102 Moll 31. Date filed (Month, Day, Year) 32. Re State NOV 2 2006 Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HENNINGSEN Physician LOUISE MARGARET 26, 2006 6:15  $A^{M}$ November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Village Care and Rehab. Montgomery Village Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛱 F 96 22,1910 547-01-4176 Iowa Director Aug. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 1 ☐ Yes 2X No Montgomery Village Director MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20886 United States 20305 Highland Hall Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify. White ş 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Frye Herman Clarence Lage 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 19a. Informant's Name/Relationship (Type. Print) 20305 Highland Hall Drive Montgomery Village, Elizabeth Winnor (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov. 27, Metropolitan Crem. Alexandria, Va. 2006 Ò 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home wells 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications but caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Coronary Artery Disease /Medical Due to (or as a consequence of) **Examiner** Acute Myocardial Infarction Sequentially list conditions, it any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to (or as a consequence of) Examiner physician and s the burial-trans Due to (or as a consequence of) Physician/Medical use as attending IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2X No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown certificate has been signed rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy perforn 2X No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 24 hours after death.

le Funeral Director: A pletely filled in by the fi r death. 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. Hospital or Attending Physician;

the Maryland

Baltimore, Maryland 21215-0036

To the Hosp within 24 hor To the Fune completely fi 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Germantown, Md. 20874

A1165 MD

29c. License number

29d. Date signed (Month, Day, Year)

November 27, 2006

State Registrar

Vinu Ganti M.D.

29b. Signature and title of certifier

(Check only



		1	For State		State of	f Maryland		irtment of			Mental H	/gienę Reg. Né:	71116	39	839
			Registrar  1. Decedent's Name (Fin	st, Middle, Last)							2. Date of D	eath		3. Time	of Death
	Physicia		Donald Raymo		r						Month Novemb	Day		12:00	а м
1	/Medic Examin		4a. Facility Name (If not			mber)		4b. City, Town	n, or Locati	on of Dea			County of Dea		
	Examin	er	Holy Cross H					Silver	Comin	~		M	mtanmars	,	
	Euporal		5. Social Security Number			7. Age (In yrs. Ia	ast birthday)	If Under 1 Ye	ar If Un	der 24 Hrs	8. Date of B	irth	ontgomery 9. Bir	thplace (State	or Foreign
	Funeral Director		091-28-1904	15	M 2□F	70	Yrs.	Months Da	ys Hou	rs Min	May 31.	1936		ountry) 7 York	
			Usual Residence of Dec	edent											
	ylan		10a. State 10b	. County		10c. City	, Town or Lo	cation						10d. Inside	1
	a-f s	Sto	Maryland M	Montgomery			Wheat	n						I I I YE	s 2√∏No
	or 28	Director	10e. Street and Number					10f. Zip Cod	е			10g. Citi	zen of What C	ountry?	
	within 72 hours after death with the Maryland ane. then "natural", or items 23a or 28a-f show the Madical Examiner rust be notiliad at	a	11741 Colleg	je View Dr	ive				20902				USA		
	ems Fr	Funerai	11. Marital Status		12. Was Dece Armed Fo	edent Ever in U.S rces?	3. 13. Y	Was Decedent of Yes, specify C	of Hispanic	Origin? (	Specify Yes or North Rican, etc.)	0-	<ol> <li>Race - Am- Black, Whi</li> </ol>		
9	after or it	F	1 Never Married		1 ⊠Yes If Yes, Giv			I□Yes 2□x	No Spe	city:			Specianite		
21215-0036	ural',	d by	3 ☐ Widowed 4 ☐x			ates: 1961-6						101 10			
5-	72 h	Completed		Decedent's Edu nly highest grade			(Give	lent's Usual Oc kind of work do DO NOT use re	ne during i	most of wo	orking	16b. Ki	nd of Business	Vindustry	
12	vithin hen	E D	Elementary/Secondary	y (0-12)	College (1	I-4or 5+)			,			D	. T. b.		
2	lied v lygie her t		17. Father's Name (First	Middle (ast)	4		кеат г	state Ag		other's Na	me (First, Midd		al Estate Sumame)		
ă Z	d ol	Be	Raymond Hei								ne Claren		,		
Maryland	d Mei mark matic	ဥ	19a. Informant's Name/		ne Print)		10h Mailir	a Address /Str	eet and Mu		Rural Route Num		r Town State	Zin Code)	
Nai	12 st h and 7 is n		James D. Heid		pe, rang			•			Wheaton.			2.p 0000)	
e,	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene if them 23a or 28a-1 show item 27 is marked other then "natural", or items 23a or 28a-1 show other traumatic event, the Medical Exeminar Huat be notified at		20a. Method of Dispositi			20b. Pl		sition (Name o				,	cation - City or	Town, State	
altimore,	permit. Pages: Department of H Important: If ite any injury or ot		1 ☐ Burial 2 ☑ Cr	emation 3 🗆 P	emoval from	State C6	metery, crei	natory or other	place)	Nove	mber 28,				
Ë	tant rant		4 Donation 5			Meti		n Cremat		o o dibe	2006		ndria, V	irginia	
Bal	Deparement Deparement		21. Signature of Funera	I Service Licens	90						meral Hom				
	GD 2 e d		23a. Part1. Enter the di	23 ce	)all	7					West, Si		Spring, M	D 20901 Approxim	ate
***	Physician /Medical Examiner  portion and private transit  private transit	Il Examiner	Immediate Cause (Fina disease or condition resulting in death)  Sequentially list condition if any, leading to immediate cause. Enter Underlyin Cause (Disease or injurt that initiated events resulting in death) Last	ons, diate	Due to	orulmonary (or as a consequent catory Fai (or as a consequent (or as a consequent)	lure		n Deas	c.				Onset an	
8760,	cate b	dica			1										
P.O. Box 6	death certiff e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 □ Yes 2 □ No 9 □ Unknown	ignant hths?	1 Live b	tcome of pregna birth 2 ☐ Fetal nant at time of de own	death 3	]Ectopic pregna ] Other (specif)		-			23d. Date of de Month	olivery Day	Year
Vital Records, P.	ge g	þ	Part II. Other significant Tobacco Abus			eath but not resu	ulting in the u	nderlying cause	given in P	art I.		tobacco i Yes 2	use contribute t □ No 3 ⊋ P		f death? □Unknown
Ö	law requires as been sign 2 should be	Completed									24a. W	e 20	24h Were a	utopsy finding	ne available
3ec	The law cate has page 2:	E E									aut	opsy formed?	prior to death?	completion o	cause of
=	i: The icate h										1 ☐ Yes	2 🔀 No	1 ☐ Ye	s 2 No	
Z:	Physician: Th r this certificate ral director, pag	Be	25. Was case referred t examiner?	_	lospital:						eath (Check only				
<del>o</del>	Phys this al dii	၉	1 ☐ Yes 2 🔀 No 27. Manner of Death		1 XX		ER/Outpaties 28b. Time o	nt 3 DOA		Nursing	Home 5 ☐ Re			ecify)	
	ding h. After funer	lo	1 Natural 5	Pending	(Mon	th, Day Year)	Injury		njury at Work? 1 □ Yes	2 □ No	250. 50501.5	5 11 5 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	y occurred		
isi	Attending in death.	icat	2 Accident 3 Suicide 6	investigation  Could not be	28e Place	of Injury - At ho	me farm st				28f. Location	(Street ar	nd Number or P	Rural Route N	ımber.
Division	5 t t o	Certification:	4 Homicide	determined	build	ing, etc. (Specif)	<i>(</i> )	cot, ractory, on	100			own, State			,
	Hospita 4 hours Funerel	edicai C	29a. Certifier 1 🔀 (Check only 2	Certifying Phy Medical Exami	ner: On the b	e best of my kno basis of examina iner stated.	wledge, deat tion and/or in	h occurred at th vestigation, in r	ne time, dat my opinion,	e and place	ce, and due to the	e cause(s e, date and	) and manner a d place, and du	is stated. e to the cause	e(s)
	To the within 2 To the complei	Me	29b. Signature and title	of certifier	0 1			29c. Lie	ense num	ber		29d. Da	te signed (Mor	ith, Day, Year	)
	₩ \$ ₩ Ö		1 de	huh	Jal	m 20		H	006	458	8	11	1271	06	
	F.L	/	30 Name and address Ashish Tolia	of person who c	ompleted cau	se of death (Item	23a) (Type,						, ,		
	A		Asnısh 'lblia	I, M.D.	TOOU FOI	rest Glen	Road, S	oliver Sp	ring, l	MD 209					
	Sta Regist	ate rar	31. Date filed (Month)	IV 'Z'9 2	006 32.	egistrar's Signa	ture	mile							

			1 - For State Registrer	State of M	laryland		artment of H Tificate of L		i Mental Hyg ™	iene 006	39840
			1. Decedent's Name (First, Middle, Last)	-					2. Date of Deat	h	3. Time of Death
	Physici /Medic		E	lizabeth	L. Hos	sey			Dawler	CHY 2006	3:08 PM
4	Examin		4a. Facility Name (If not institution, give	treet and number	)		4b. City, Town, or	Location of De		4c. County of Deat	
			Union Hospital				Elkton			Ceci1	
	Funeral		5. Social Security Number 6. Sex		ge (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 H Hours Mi		9. Birt	hplace (State or Foreign untry)
	Director		232-48-2448	M 25 F	'6	Yrs.	Months Days	Hours IVI	July 1,		rginia
	D .		Usual Residence of Decedent		10c. City, 7	Four or La					404 1 24 02 12 2
	anyia shov	_	10a. State 10b. County				Cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	88 -f	octo	Maryland   Cecil		Elk	ton					Λ
	Vith t	Director	10e. Street and Number				10f. Zip Code		11	0g. Citizen of What Co	
	within 72 hours after daath with the Maryland ene. then "natural", or Items 23a or 28a-f show ha Madical Exarthina must be multified at		2 Chesapeake Apai				21921			United St	
	er da	Funeral	T. Marian Olatos	12. Was Deceden Armed Forces	?	13.	Mas Decedent of His f Yes, specify Cubai	spanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White	
36	s aft	by F	1 Never Married 2 Married 3 ☑ Widowed 4 □ Divorced	1 ☐ Yes 2 [V If Yes, Give Year or Dates:	NO		1 ☐ Yes 2 📉 No	Specify:		Specify: T.TL	÷ 4. a
8	hou	edi	15. Decedent's Edu		1	16a Dece	dent's Usual Occupa	tion		16b. Kind of Business/	ite
5	in 72	Completed	(Specify only highest grade	completed)		(Give	kind of work done d DO NOT use retired	uring most of w	rorking	TOD. TAING OF BUSINESS	moderry
12	d withir giene. or then	E	Elementary/Secondary (0-12)	College (1-4or	5+)	Hor	nemaker			In Her C	wn Home
B	be filed htal Hygi ed other event, II	Be C	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle, A		***************************************
Maryland 21215-0036	2 should be filed and Mental Hygli is marked other aumatic event, II	To B	John Paul Hyler					Edna	L. Bennett	•	
37	d 2 should th and Men 17 is marke traumatic	-	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailir	ng Address (Street a			City or Town, State, Z	(ip Code)
	コニトラ		Elizabeth L. Hose	ey/Self		2 Che	sapeake A	partmen	ts, Elkto	n, Marylan	d 21921
Baltimore,	s 1 and of Healt item 2 other		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of natory or other place			20c. Location - City or	
Ę	permit. Pages 1 Department of the importent: if ite any injury or ot once.		1   Burial 2 □ Cremation 3 □ R  Under (Specify)	emoval from State	'St.	John'	s Methodi			Lewisville,	PΔ
=======================================	nit. I		21. Signature of Funeral Service License	90 1.	Ceme		. Name and Addres	s of Facility			
ä	Depa impo any i		Amued 8	Q. it.		Hi 10	cks Home	tor Fur	nerals, P.	A. ton, Maryl	and 21021
			23a. Part1. Enter the disease, or compli	cations that cause	d the death.						Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final	le cause on each	iine.	1	- 1	45			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to for a	a consequer		Indarch	tion			minutes
	Examiner				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	a consequer	nea of).					
/	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events								
o	an ar rial-tr		resulting in death) Last		s a consequer	nce of):					
8760,	sate be executed physician and the burial-translt	dlcal		l							
9	ntifica ng ph as th	Med	IE EE WALE								
Вох	death certific a attending p id for use as i	Physician/Med	23b. was decedent pregnant	3c. If yes, outcome 1 Live birth			Ectopic pregnancy			23d. Date of deli	•
	0 80	SICI	in the past 12 months? 1 ☐ Yes 2 💢 No	4☐ Pregnant a			Other (specify)			Month	Day Year
P.O	The law requires that the de ite has been signed by the a baga 2 should be detached	پر کر	9 Unknown								
	es tha igned be de	þ	Part II. Other significant conditions cor	tributing to death	but not resulting	ng in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ord	w requir been si should			-					1 🗆 Ye	s 2 □No 3 □ Pro	obably 4 Munknown
of Vital Records,	e law r has be ja 2 sh	ompleted							24a. Was ar		topsy lindings available completion of cause of
Ě	The ate has page	Com							perform	ned? death?	
ita	inn: intification:	Be (	25. Was case referred to medical examiner?					26. Place of D	eath (Check only one		
<b>/</b>	Physician: this cartific al director,	To	1 ☐ Yes 2 ☐ No	ospital: 1   Inpat	ient 2 EF	VOutpatier	t 3□ DOA Othe	4 Nursing	Home 5 ☐ Reside	nce 6 Other (Spec	cify)
0			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 28	3b. Time of	28c. Injury Work	at ?	28d. Describe ho		
Ö	Attending r death. ector: After by the fune	atle	2 ☐ Accident investigation					res 2 □ No			
Division	il or Attendir after death. Director: Al	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	jury - At home	e, farm, str	eet, factory, office		281. Location (Str City or Town	eet and Number or Ru , State)	ral Route Number,
	ital or its afte rei Dir			1							
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Examin	ner: On the basis	of examination	edge, death	occurred at the time	e, date and pla inion, death oc	ce, and due to the ca	use(s) and manner as ite and place, and due	stated. to the cause(s)
	the hin 2 the I	Med	one)	and manner s	tated.						``
	7 v. r. o		29b. Signature and title of certifier	12-			29c. License		1	9d. Date signed (Monti	
•			sel !!		m	2	DOOS	5509	Ā	December 6	th, 2006
	2		30. Name and address of person who co		death (Item 2:	4.1	1 1	0:1			
	V		31. Date filed (Month, Day, Year)	1950VI	rar's Signatur	n Ho	spital,	Elkton	1 MD	21921	
	Sta Registr				iais signatur 🎜	Lan	DE E				
	riegisti	206	DEC 1 4 2006	Desire	1 15	LATION					

ase Type or Print in Black Indelible Ink e of Aryland / Department of Health and Mental 2006 39841

UNK UNK		State of Sta	Health and Death	d Mental			00 0004
Physiciar	n/	tegistrar 1. Decedent's Name (First, Middle,Last)		-	2. Date of Deat	Day Year	3. Time of Death 0057 hrs
Medical Examin		Joseph Patrick Hufnell  4a. Facility Name (if not institution, give street and number)  44	b. City, Town, or	Location of De	November	4, 2006 4c. County of E	
5		Harbor Hospital	Baltimore				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Tast birthday)	If Under 1 Yea  Months Days		Hrs. 8. Date of Bir 3/7/1	F	B. Birthplace (State or oreign Pennsy I vani Country)
Director	-	216-24-3381 1X M 2 F 44 Yrs.  Usual Residence of Decedent			3/1/.	1902	Country)
v any	t	10a. State 10b. County 10c. City, Town or Location	n				10d. Inside City Limits
/land -f shov	ই		dgewate	r	1	0g. Citizen of What	1 Yes 2 X No
ne Mary or 28a	Director	10e. Street and Number 319 Hamlet Circle	2103	7		US.	*
with the ms 23a			Decedent of His		( Specify Yes or No	- 14. Race - A	American Indian, Black,
r death	Funeral	Never Married 2 Married 1 X Yes 2 No	_		erto Ricari, etc.)	0*	
urs afte	٦	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent'	Yes 2 X No	tion (Give kind		Specify:	White ness/Industry
6 172 hou an "nai	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life Imber	e. DO NOT use	retired)	Plumb	ina
. within giene.	g mo	17. Father's Name (First, Middle, Last)		18 Mother's N	ame (First, Middle, I		Tilg
21215-0036 Related Filed within 7 Mental Hygiene marked other than cevent, the Medical	Bec	William Joseph Hufnell				ret Kelly	
	ျှ					nber, City or Town, r, MD 210	
and 2 sho Health and item 27 is	1	20a. Method of Disposition 20b. Place of Disposit	tion (Name of ce		Date		ity or Town, State
altimore mit. Pages 1 a partment of He portant: If its ury or other t		1 X Burial 2 Cremation 3 Removal from State Holy Cross		ry 12	2-9-06	Brooklyn	Park, MD
part part		21. Si vur f Fu eral rvice Licensee 22. Na					neral Home
		29 / 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the					, MD 21037  Approximate Interval
Physician /Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Cocaine and Ethanol Intoxication					Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):					
	ē	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):					
. 2	amir	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):					
50, se be executed ysician and burial - transit	edical Examiner	d					
O, e be exe sician burial						Tool Date of de	
Division of Vital Records, P.O. Box 6876( Bospital or Attending Physician: The law requires that the death certificate 24 hours after death. Funeral Director: After this certificate has been signed by the attending phytel filled in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director.	an/M	nast 12 months /	tal death 3	Ectopic pre	egnancy	Month	Day Year
Box 6 e death ce the attended for use	Physician/M		ner (Specify)			İ	1
O. E		Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause	given in Part I.			ute to the cause of death?
S, P. uires th	ed by				_		Probably 4 Unknown
cords, law requir has been s	Completed				24a. Was autop	osy prio	ere autopsy findings available or to completion of cause of ath?
tal Rec		OF Was are referred to medical	26 Piac	e of Death (Ch	1 Yes		Yes 2 No
Vital Rec ysician: The his certificate director, page	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient		Othor	ursing Home 5	Residence 6	Other:
Division of Vital Records, rate death. Is after death. In Director: After this certificate has been side in by the funeral director, page 2 should be	-	27. Manner of Death 28a. Date of Injury 28b. Time of Ir		ury at Work?	Unknown	how injury occurred	
ivision or Attend after death Director:	catio	Natural 5 Pending Investigation Nov 4, 2006 0030 hrs  Representation Nov 4, 2006 0030 hrs  28e. Place of Injury - At home, farm, stree		Yes 2 V No		Street and Number	or Rural Route Number, City
Divisior ospital or Attent hours after death uneral Director:	Certification:	3 Suicide 6 ✓ Could not be determined (Specify) Local Street	a, ractory, office	building, etc.	or Town, S	State)	reet, Brooklyn, MD
Div e Hospital o 124 hours af e Funeral D		29a. Certifier Chack only 1 Certifying Physician: To the best of my knowledge, death occurr	red at the time, c	late and place,	and due to the caus	se(s) and manner a	s started.
To the within 2 To the complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	ion, in my opinio		red at the time, date		e to the cause(s)  (Month, Day, Year)
	2	29b. Signature and title of certifier		.M.E.		November 4	
5		30. Name and address of person who completed cause of death (Item 23a)				<u> </u>	
		Ana Rubio MD. Assistant Medical Examiner 111 Penn S		ore, MD 21	201		
st:	ate	31. Date filed (Mooth, Day, Year) 32/Registrar's Signature	le				

	1	For State		State of Ma	arylar			ent of F		nd Mental		2000	2001.2
		Registrar  1. Decedent's Name	(First Middle La	nst)			,erunc	ale of	Dealli	2. Date	Reg. I	No. UU	3. Time of Death
Physician	1		Beall	Hodges						Monti		Day Year	
/Medical				re street and number)			4b. (	City, Town, o	r Location of I	Death	الماري	4c. County of Dea	
LAMITIME		Citize	ENS NE	115/201	40	nc	H	avre	de	Ero	- 0	Hair	fand
Funeral	1	5. Social Security N		_		. last birtho	Mon	nder 1 Year ths Days	If Under 24	Hrs. 8. Date of	of Birth h, Day, Ye, 22	ar) 9. Bi	inhplace (State or Foreign Country)
Director		219-18-5	514	1 🔀 M 2 🗆 F		85 Yr	S.	Liio Days	Hours	Nov.	22,	1921 Ma	ryland
and	-	Usual Residence of 10a. State	10b. County		10c. C	ity, Town o	r Location						10d. Inside City Limits
Maryl 1 sho	2 1	Maryland	Harfor	-F		Α	berde	en .					1XXes 2 No
with the Mau	2	10e. Street and Nur						. Zip Code			10g.	Citizen of What C	Country?
h with	2	145 Po	st Road					210	01			USA	
6 after death w or treme 23a		11. Marital Status		12. Was Decedent Armed Forces?	Ever in U	J.S.	13. Was D	ecedent of H	lispanic Origin	? (Specify Yes	or No-	14. Race - Am Black, Wh	
or the			ed 2 Married	1 ⊠Yes 2 □ h	No.			s 25 No	Specify:	dono mozn, en	·· /		White
ind 21215-0036  be filed within 72 hours after death with the Maryland hal Hygiene. Id other then "natural; or iteme 23e or 28e-f show event, the Medical Exemplear must be notified at Be Completed by Funeral Director	2	3 Widowed		Year or Dates:	WW						1.01		
121215-00 led within 72 hou spiene. Ner then "nature her the maintener her the Completed Completed			15. Decedent's E lify only highest gr			16a. 0	ecedents Bive kind o fe. DO NO	Usual Occup f work done : OT use retired	ation during most o d)	f working	160	. Kind of Business	s/industry
vithi iene.	5	Elementary/Seco 12	ndary (0-12)	College (1-4or 5	5+)			l Serv			Į	US Gover	nment
nd 2 be filed tal Hyg d other	0	17. Father's Name		"		1				Name (First, M	iddle, Maid		
Vlar Suld be Menta mrked mitc or	2	Th	omas Ho	dges				i	Gr	ace Bea	all		
E age		19a. Informant's Na	ame/Relationship	(Type, Print)		19b. M	lailing Add	ress (Street	and Number	or Rural Route N	lumber, Cit	ty or Town, State,	Zip Code)
and and sealth m 27	-	Jane L.		wife)	1				Aberd	een, MD			
Baltimore, Mapermit. Pages 1 and 2 Depermit. Pages 1 and 2 Depertment of Health a Important: If item 27 is any injury or other transpace.		20a. Method of Disp 1 ☑ Burial 2		☐Removal from State	1		crematory	or other place		Date		Location - City o	
altim mit. Pa pertmen portant: rinjury			5 Other (Speci		Ha	rford				s 12/8/0	)6 Abe	erdeen,	Maryland
Dan permi		21. Signature of Fu	neral Service Lice	nsee	· No	101			ss of Facility	Tarring	g-Caro	go Funer	al Home, P.A.
	+	23a Part1 Enter ti	ne disease or com	no cations that caused	the dea	- 40-1	-		<del></del>	nd 21001		J 	Approximate
		shock, or hea Immediate Cause	rt failure. List only	one cause on each li	ne.	1	11	Lach	1/ //	1.11	1		Interval Between Onset and Death
Physician /Medical	1	disease or conditio resulting in death)	n .	a Due to (or as	2 00000	1/4	un	0410	CV	weer	(		1
Examiner			- 1	Due to (or as	a conse	querice or)	,						
	0	Sequentially list con if any, leading to in cause. Enter Unde Cause (Disease or	nditions, imediate	b. Oue to (or as	a consec	quanca of)							1
o, % executed an and ial-transit		that inflated events		c									
e exe	3	resulting in death) l	_ast	Due to (or as	a conse	quence of):	:						
8760, Recate be executed physicien and the buriat-transit dicase.	2			_ d									
		IF FEMALE:		22a II usa sutsama	of 240.00								
D. BOX 6 death certific e attending ted for use as	2	23b. Was decedent in the past 12	months?	23c. II yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fet	al death	3 □Ectop 5 □ Other	ic pregnancy	/			23d. Date of de Month	alivery Day Year
P.O. that the de detached detached	72	1 □ Yes 2 9 □ Unknown		9□ Unknown	LIME OF	ueain	5 L. Otne	r (specify)					
Records, P.O. Box 6 The taw requires that the death certificate has been signed by the attending rage 2 should be detached for use as completed by Physician/Me		Part II. Other signif	icant conditions	contributing to death b	ut not re	suiting in th	ne underlyi	ng cause giv	en in Part I.	23e.	Did tobacc	o use contribute	to the cause of death?
										_	1 🗌 Yes	2 No 3 P	Probably 4 Minknown
ecord aw requii											Was an	24b. Were a	autopsy findings available completion of cause of
al Record The law requirements to see has been single 2 should	5									101	autopsy performed es 2	? death?	
F Vital Re yeician: The lis certificate his director, page	D	25. Was case refer	red to medical						26. Place of	Death (Check of			3 22.110
of Vita Of Vita Physician: this certific	5	1 ☐ Yes 2	Ño	Hospital: 1 Inpatie	ent 2	☐ ER/Outpa	atient 3	DOA Oth	4 Z MUISI	ng Home 5□	Residence	6 □Other (Spe	ecify)
Sing Ph. Alter th funeral funeral	5	27. Manner of Deat	h 5 □ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Tim Inju	ry	28c. Injur Wor			ribe how in	njury occurred	
Si Si	200	2 Accident 3 Suicide	investigation 6 □ Could not be			ļ	М		Yes 2□No				
Division of tall or Attending P is after death.  al Director: After the director and in by the tunera		4  Homicide	determined		ury · At r c. <i>(Speci</i>	nome, farm ify)	, street, ta	ctory, office		City o	on (Street or Town, St	and Number or F ate)	Rural Route Number,
Hospital Hospital Hospital Hospital Hospital Hours a		29a. Certifier	1 Certifying P	hysician: To the best	of my kn	owledge d	eath occur	rred at the tin	ne date and r	place, and due to	the cause	o/s) and manner a	as stated
DIVI To the Hospital or At within 24 hours alter or To the Funeral Direct completely filled in by Medical Certiff		(Check only one)	2 Medical Exa	miner: On the basis of and manner sta	f examin	ation and/o	or investiga	ition, in my o	pinion, death	occurred at the t	me, date a	and place, and du	e to the cause(s)
To the within 2 within 2 comple	M	29b. Signature and	title of certifier	16	21	/		29c. Licens	e number	,	29d. I	Date signed/(Mon	(th, Day, Year)
		> >	Mark	1 Do	rt U	9			4280	00		12/1/11	16 /
54		30. Name an addr	ess of person who	completed cause of d	leath (Ite	m 23a) (Ty	pe, Print)	211	/	11 1 1		1. 1	SA Int
211		140	MY	12101	NO	MIL	) .	2/9	DUTH	Colo	NA	WH 4	WOI HA
State		31. Date filed (Mon		32. Registr	ar's Sign	ature	and a					/	121074
Registrar	50	UE	C 1 3 200	U JAGARA	200	6							81010

06-08950 Mel Wayne Joyner

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	1- For State Certific	eate of Death	Reg. No.
Physician/	Decedent's Name (First, Middle,Last)		2. Date of Death 3. Time of Death 4.
Medical Examiner	Mel Wayne Joyner	4h City Tayan and position of Doob	November 24, 2006 1308 hrs
	4a. Facility Name (if not institution, give street and number) 10239 Prince Place Apt. 302	4b. City, Town, or Location of Death  Largo	4c. County of Death Prince George's
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last bit 578-74-7702 1XM 2F 52	thday) If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) DC
ow any	Usual Residence of Decedent   10a. State	nor Location ington	10d. Inside City Limits 1 X Yes 2 No
the Maryland a or 28a-f show tiffed at once.  Director	10e. Street and Number 5911 3rd St., N.E.	10f. Zip Code 2 0 0 1 1	10g Citizen of What Country? U.S.A.
21215-0036 Jild within 72 hours after death with the Maryland Mental Hygiene marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once o Be Completed by Funeral Director	11. Marital Status  1 X Never Married 2 Married Armed Forces?  1 Yes 2 X No	13. Was Decedent of Hispanic Origin? ( Spe If Yes, specify Cuban, Mexican, Puerto R	
urs after d itural", or aminer m	3 Widowed 4 Divorced if Yes, Give Year or Dates:	1 Yes 2 X No specify:  Decedent's Usual Occupation (Give kind of wo	
5-0036 ed within 72 hour tygiene other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retire anitation Worker	Dept. of PublicWork
MD 21215-0036 at should be filed within 7 th and Mental Hygiene n 27 is marked other than numatic event, the Medica To Be Comple	17. Father's Name (First, Middle, Last)  Jay Joyner	Vandal	,,,,,
AD 2 sho 2 sho mark	*		ural Route Number, City or Town State, Zp. Code 1 1 Washington, DC 2001 1
Pages I Pages I ment of H taut: If i or other	1 X 8urial 2 Cremation 3 Removal from State 4 Donation 5 Other, Specify:		Date 20c. Location - City or Town, State 1/06 Brentwood, Md.
	21. Signature of Funeral Service Licensed	411 Kennedy St.	iversal Mortuary ,N.W. Wash.DC 20011
Physician /Medical Examiner	23d. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Atherosclerotic Due to (or as a consequence of):		respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
ner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause		
tted J ansit Examiner	(Disease or injury that initiated events resulting in death) Last		
760, icate be executed sphysician and the burial - transit	UNPENDED AMENDED		
	4 Vec 2 No 0 Helmoure Final	2 Fetal death 3 Ectopic pregnan 5 Other (Specify)	23d. Date of delivery  Icy Month Day Year
oed deta	Part II. Other significant conditions contributing to death but not resulting Diabetes	ig in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Vunknown
Division of Vital Records, P.( rate: Attending Physician: The law requires has rearise death rate for the After this certificate has been signed lied in by the funeral director, page 2 should he det ertification: To Be Completed by			24a. Was an 24b Were autopsy findings available prior to completion of cause of death?
tal Rectinant The Certificate I	25. Was case referred to medical	26.Place of Death (Check or	1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital tysician this cert	examiner?  1 V Yes 2 No  Hospital: 1 Inpatient 2 ER/C	- lower -	Home 5 Residence 6 ✔ Other: Scene
tending Phesau or: After t the funeral	27 Manner of Death  1 ✓ Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day, Year)  28b.	Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
Division o sputal or Attending tours arize death breed breedor: Afte filled in by the fune Certification:		arm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division of Vital Records, F To the Hospital or Attending Physician: The law requires within 2s hours arizer death To the Funeral Director. After this certificate has been sign Completely filled in by the funeral director, page 2 should he Medical Certification: To Be Completed I	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.		
We S	29b Signature and title of certifier	29c License number O.C.M.E.	29d. Date signed (Month, Day, Year) November 25, 2006
CR	30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner	11 Penn Street, Baltimore, MD 212	201
State Registrar	31. Date filed (Month, Day, Year) NOV 2 8 2006 32. Registrar's Signature	de	

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State

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31. Date filed (Month, Day, Year) NOV 2 8 2006

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



Registrar

29c. License number

D0033503

11. 25,06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear 2006 ANNA L. **JAMES** 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death UNION MEMORIAL HOSPITAL BALTIMORE 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🔀 F 82 3-8-1924 219-22-5768 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 Nes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2111 WEST SARATOGA STREET 21223 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 【XNo Specify: BLACK 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE PRIVATE 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WATTS SAMUEL DONELLA BROWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLARENCE CHASE - SON 9808 SAPELO ROAD, BALTIMORE, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN CEMETERY 12/1/06 4 Donation 5 Dother (Specify) BALTIMORE, MD 22. Name and Address of Facility TAYLOR 'S FUNERAL HOME 21. Signature of Funeral Service Lies 1722 NORTH CAPITOL ST., NW WASH. DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a onsequence of): Renal Disease End Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hyper tension

Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Yo Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 № No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 🛣 No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical **Examiner** law requires that the death certificate be executed

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

23a or

Director

Funeral

Completed

ပ

7 Is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notified

within 72 hours after

d 2 should be filed with and Mental Hygier 7 Is marked other the

permit. Pages 1 and 2 sh Department of Health an Important: If them 27 Is r any Injury or other traur

Baltimore, Maryland 21215-0036

P.O. Box 68760,

/Medical

Examine burial-trar attending physician Physician/Medical as the l for signed by the a þ Completed Be Certification: To this After t

Division or Vital Records, completely filled in by the funeral Hospital or Attendi 24 hours after death. Funeral Director: A To the Hospital of within 24 hours at To the Funeral C D

Medical

State Registrar from Mee Can

m.D.

29c. License number #AT2438946

Str Avenue Towson MO 2/204

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

at 303 Charles Soen Mee Chung

31. Date filed (Month, Day, Year) NOV 2 9 2006

29b. Signature and title of certifier

4 Homicide

29a. Certifier

32. Registrar's Signature

			1 - State Registrar	ate of Maryland / I	Department of Health  Certificate of Death	and Mental Hygie		1846
	Di		Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	of Death
	Physici /Medio		JUSTINE VIRGINIA	JONES		Decambe	DU 200 8:3	BPM
}	Examir		4a Facility Name (If not institution, give street	u Cente	4b. City, Town, or Location	1	4c. County of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bit	thday) If Under 1 Year If Under 1 Year Months Days Hours	Min. 8. Date of Birth (Month, Day, Y		
	Director		579-64-0221 Usual Residence of Decedent	59		OCT.27,	1947 WASH.,D	C
	Maryland -f ehow		10a. State 10b. County	10c. City, Tow	n or Location		10d. Inside	City Limits
	r 28a-f ehow	to	MARYLAND CHARLES		WALDORF		1 🗆 Y	es 2∏No
	or 28	ire	10e. Street and Number		10f. Zip Code	10g	Citizen of What Country?	
	deeth with the ms 23a or 28a criunt be nutt	Funeral Director	212 BARKSDALE AVE		20602		U.S.A.	
		iner	11. Marital Status 12. W	as Decedent Ever in U.S. med Forces?	13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	igin? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.	
98		by Fu	1 Never Married Narried 1.	□Yes 2√2XXO Yes, GiveXXX	1 ☐ Yes XONo Specify			
5-0036	72 hours after "natural", or ite		3 Widowed 4 Divorced Ye	ar or Dates:			Specify: WHITE	
7	72	Completed	15. Decedent's Education (Specify only highest grade com	oleted)	Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired)	st of working	b. Kind of Business/Industry	
2121	yene. r then	mc.	Elementary/Secondary (0-12) Co	tlege (1-4or 5+)	BEAUTICIAN	D	EXIMV CHORC	
	filed with Hygiene other the	Be C	17. Father's Name (First, Middle, Last)			er's Name (First, Middle, Mai	EAUTY SHOPS  den Sumame)	
Maryland	s 1 and 2 should be filed f Health and Mental Hyg Item 27 ie marked othe other treumatic event,	To B	NEWTON CUTSHAW		MA	RY SMTTH		
ary	shound N	-	19a. Informant's Name/Relationship (Type, Pr	int) 19b	Mailing Address (Street and Numb		ty or Town, State, Zip Code)	
	alth a alth a 27 ic		ROBERT H. JONES, JE	RSPOUSE 21	2 BARKSDALE A	VE. WALDORF	MD 20602	
J.	of He item		20a. Method of Disposition	20b. Place o	Disposition (Name of ry, crematory or other place)		Location - City or Town, State	
Ĕ	Page ment: if ant: if		1 <b>X</b> Xurial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	at from State	VETERANS CEM	. 12-13-06	THET.TENHAM !	ME
Baltimore,	permit. Pages 1 and Department of Heali important: if item 2 eny injury or other 2005.		21. Signature of Juneral Service Licensee	M00479	22. 13 me and Address of Facili	ty		nD.
-	g ⊊ ≘ g		Muhal C.	<b>*</b>	RAYMOND FUN			
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that mused the death. Do see each line.	not enter the mode of dying, such as	cardiac or respiratory arrest,	Interval E	Between
15	Physician		Immediate Cause (Final disease or condition	avdiac 1	trzythuna		Onset an	d Death
	/Medical Examiner		resulting in death)	ue to (or as a consequence	traythmia Artery Dis			
		_	Sequentially list conditions, if any, leading to immediate			eare		
/	ed sit	nine	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	or):			
_	icate be executed physicien and s the burial-transit	Examiner	that initiated events	Due to (or as a consequence	of):			
8760,	sicien buria	alE		Hyperchs	les ferole un	٩		
687		edicai	d	t t				
Вох	death certif e attending id for use as	Physician/M		es, outcome of pregnancy			23d. Date of delivery	
ă	d for	Cia	in the nast 12 months?	Live birth 2 Fetal death Pregnant at time of death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		Month Day	Year
P.O.	oy the	hys	9 Unknown 9D	Unknown				
	w requires thet the de been signed by the should be detached	by P	Part II. Other significant conditions contributi			. 23e. Did tobac	co use contribute to the cause of	f death?
Records,	quire an sig	edt	Severe /2heur	atold Ar	tun'tis	1 Yes	2 No 3 Probably 4	Unknown
သို့	awre ts be	piet				24a. Was an	24b. Were autopsy finding	s available
æ	The I	Completed				autopsy performed		cause of
Division of Vital	ding Physicien: The lav h. After this certificete has funeral director, pege 2	Bec	25. Was case referred to medical examiner?		26. Place	of Death   Check only one	10 103 2010	
>	Physicien: this certific ral director.	Jo.	1 ☐ Yes 2 No Hospita	l: 1 Inpatient 2 ER/Ou	tpatient 3 DOA Other: 4 Nu	ursing Home 5 🗆 Residence	6 Other (Specify)	
0 _	ng Pl		27. Manner of Death 1. Natural 5 ☐ Pending		ime of 28c. Injury at hijury Work?	28d. Describe how i		
Sio	Attending r death. sctor: After by the fune	cati	2 Accident investigation		M 1 Tyes 2	No		
Ξ	or Att	Ĕ	3 Suicide 6 Could not be determined 28e	<ul> <li>Place of Injury - At home, fa building, etc. (Specify)</li> </ul>	rm, street, factory, office	28f. Location (Stree City or Town, S	and Number or Rural Route Nu ate)	mber,
	urs al	ပီ						
	Hosp 24 ho Fune tely fi	Ca	(Check only 2 Medical Examiner: O	n the basis of examination an	, death occurred at the time, date an	d place, and due to the cause th occurred at the time, date	e(s) and manner as stated. and place, and due to the cause	(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification:	one) ar  29b. Signature and tile of certifier	d manner stated.	29c. License number		Date signed (Month, Day, Year)	· ·
	⊢≯⊬ŏ			- Aug	5200		17/2006	
	/	i	30. Name and address of parson who as -1-1-	ad cause of don't (to- 00-)	Type Print)			
	9		30. Name and address of person who complete	or cange of death (item 539)	E Post Office	Road would	MITTER	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signature	1		action	
	Registr		DEC 1 4 2006	Margar J.	Cosse			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year Kerling Arthur Leon 10:23 <sup>™</sup> NOVEMBER 30 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Dec. 31 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Hours Year 1**⅓**M 2□ F 80 212-24-1488 Maryland Dec. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1XXes 2 No Allegany Westernport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 225 21562 Greene St. United States 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🙀 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Air Coil Elementary/Secondary (0-12) College (1-4or 5+) Fork Lift Operator unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Floyd Kerling Margaret Fazenbaker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Kyle/ sister P.O. Box 196, Barton, Maryland 21521 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/03/ Bloomington Maryland Bloomington Cemetery 4 ☐ Donation 5 ☐ Other (Specify)

**Physician** 

/Medical

Examiner

10a. State

MD.

**Funeral** 

**Director** 

r 28a-f show notified at

'naturaj", or items 23a or dical Examiner must be

permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any injury or other traumatic event, the Medical

Director

ģ

Completed

Be

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

Examiner certificate be executed signed by the attending physician be detached for use as the buria by Physician/Medical Be Completed Certification: To funeral To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

Division or Vital Records, P.O. Box 68760,

21. Signature of Funeral Service Licensee	22. Name a	nd Address of	Facility	Boal Fur	eral	Home		
1 - Mayre Bal	111 C	hurch S	St., W	esternoc	rt, M	aryland	215	62
23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.						-	Approxima Interval Bo Onset and	etween
Immediate Cause (Final disease or condition a. T.IJNG CANCER						Т	INKNOW	
resulting in death)  Due to (or as a consequence of)	i:						MIXINO	111
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	):							
that initiated events c Due to (or as a consequence of)	iî.							
d								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐Ectopic p 5 ☐ Other (s <sub>i</sub>				230	d. Date of delive Month	ery Day	Year
Part II. Other significant conditions contributing to death but not resulting in the	he underlying o	cause given in	Part I.			contribute to ti		f death?
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25. Was case referred to medical examiner?		26.	Place of De	ath (Check only o	ne)			
	atient 3 D	OA Other: 4	Nursing	Home 5 ☐ Resi	dence 6 E	]Other (Specif	y)	
27. Manner of Death  ↑★ Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year) Inju	ne of ury M	28c. Injury at Work? 1 ☐ Yes		28d. Describe	how injury o	occurred		
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	ı, street, factor	y, office		28f. Location ( City or To		Number or Rura	ıl Route Nu	mber,
29a. Certifier (Check only one)  1 CertifyIng Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.								(s)
COL Simple and title of be differ	20	c Liconeo nu	nhor		and Date of	inned (Month	Day Vans	

DHMH 17 Rev 1/2001

Medical

State Registrar

625 KENT AVE., SUITE 102, CUMBERLAND, MD

₩egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AHMAD, MD,

Year)

31. Date filed (Month, Day, DEC

D60478

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 5:00 **Physician** A M Ί, Heather Renee Kelley 2006 December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bayside Care Center St. Mary's Lexington Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea April 30, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Days 1 □ M 2000 22 Yrs. 194-64-8427 April 1984 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo California Director Maryland St. Mary's 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 43764 St. Andrews Church Road 20619 USA Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XNever Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Nursing Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jeannette Louise Stuter David Michael Kelley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeannette Louise Upchurch/Mother 43764 St. Andrews Church Road, California, MD 20619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Dec.2, 2006 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2 Signature of Furreral Service Mattingley-Gardiner Funeral Home, P P.O. Box 270, Leonardtown, MD 20650 23a. Parvi. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lige. Immedian Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es Physician/Medical Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician sthe burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 BNo 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown þ tate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending Injury 1 Yes 2 No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after

To the Funeral Dire

completely filled in b

State

DHMH 17 Rev 1/2001

DEL 0 4 2006 Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

and manner stated.

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)
James P. Jarloe, MD, 24033 Three Notch Road, Hollywood, MD 20636

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 0300AM 2006 Vartha <u>25</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth OCCL. 10, Year 1936 9. Birthplace (State or Foreign Noccutty) Carolina 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months

10f. Zip Code

20874

70

Yrs

10c. City, Town or Location

Germantown

1 □ M 2 🕱 F

21000 Father Hurley Blvd., Unit 422

Days

Hours

Min.

10d. Inside City Limits

10g. Citizen of What Country?

United States

1 ☐ Yes 2 ☑ No

**Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it e Medical Ex. miner must he notified as Director Funeral Baltimore, Maryland 21215-0036 ğ Completed Be 2 d

**Physician** 

/Medical

Examiner

231-44-5620

10e. Street and Number

10a, State

Usual Residence of Decedent

10b. County

Maryland Montgomery

**Physician** /Medical Examiner

Box 68760,

Ö

Division or Vital Records, P.

Examine and burial-tran physician Physician/Medical the as attending use ō ed by the detached signed by the ð Completed peen has this certificate Be 2 Certification:

The law requires that the death certificate be executed After or Attending death. To the Funeral Director: completely filled in by the within 24 hours after To the Hospital

12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 漢Yes 2 No 1954— If Yes, Give Year or Dates: 1957 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Federal Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore White Ida Everee Pillois 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Kushner / Son 518 Helene Street, Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20a. Method of Disposition 20c. Location - City or Town, State November 1 ☐ Burial 2 X Cremation 3 Removal from State Alexandria, Virginia 26, 2006 4 Donation 5 Other (Specify Crematory 21. Signature of Funeral Serv 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 Ærter/the di dr heart fai ause (Final e, or complications that caused the death. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Imme e Metastatic disease or condition days cancer resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consequence of resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autops 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one 2 No Hospital: Other: 4 \sum Nursing Home 1 Tes 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Date of Injury Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifie 25,2006 MD 00064029 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brandon 9901 Medical (enter Drive 2006

Registrar DHMH 17 Rev 1/2001

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registral 39850 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month <sup>Day</sup> 2006 **Physician** MARY KNAPIK Μ. 24, 7:45 Nov. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Potomac Manor Care Potomac 8. Date of Birth (Month, Day, Year) April 15,1912 PA PA If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F 94 577-26-7866 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryls Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Director Md. Montgomery Bethesda 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code U.S.A. 5317 Yorktown Road 20816 . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No à Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Misulich Anne Karbovanec 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6964 Kyleakin Ct., McLean, Virginia Margaret LeNard/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 29, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 2006 Silver Spring, Md. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Fun (al Service License 2222 Wisconsin Ave. N.W. Washington D.C. 22101 Kurus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 15749500 15333551 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Onderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical as attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t 9 Unknown 9 Unknown page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 2 X No the Hospital or Attending Physician: ' hin 24 hours after death. the Funeral Director; After this certifica director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be To the Hospital or Atte within 24 hours after der To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760.

30

Medical 29b. Signature and title of certifi 30. Name and address of person who comp Anushiravan Dadgar, M.D.

29c. License number 40051280 29d. Date signed (Month, Day, Year)

11-17-2006

cause of tath Tem 23a) (Type, Print)

🛏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

9715 Medical Center Dr #201; Rockville,MD 20850

State Registrar 29a. Certifier

39852

	1 - For State Regist
	1. Deceden
Physician	
/Medical	
Examiner	4a. Facility
	Sou

Direct permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

Funer

Physicia /Medic Examin

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 503 Registrar

Division of Vital Records, P.O. Box 68760,

	-	<ul> <li>State</li> <li>Registrar</li> </ul>			Cei	tificat	e of i	Death			Reg. No				
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al		5. Social Security Number	6.Sex 16√2M 2□F	7. Age (In yrs.		If Under Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth ay, Year)	71		thplace (State or Forei Lynna) Lynnand	gn
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	Be	17. Father's Name (First, Middle,								(First, Middle		Sumar	ne)		
	၉	Gilbert Low		Ca	arol	Jacks	son								
		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address	s (Street	and Numb	er or Rura	l Route Numb	er. City	or Town	State, 2	Zip Code)	
		Carol R. Low	(Mothe	er)	5804	Spy	yri	Driv	ve (	Clinto	on,	Mar	gla	ind 20735	
				20h I	Place of Dispo	sition (Na	me of		D.	ate	20c L	ncation	· City or	Town, State	
		20a. Method of Disposition  X□Burial 2 □Cremation	3 □Removal fro		cemetery, crei	matory or o	other place	ce)					,		تہ
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<u>.</u>	Ì	21. Signature of Funeral Service	Licensee	^	22	2. Name a	nd Addre	ss of Facil	ity Ro.	llins	Fun	era	al H	lome, Inc	
ouce.		1 1	1	<i>.</i>	43	339 1	Hunt	: Pla	ace,	N.E.	Was	hir	gto	on, D.C.	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												20019	
		shock, or heart failure. Lis	only one cause of	n each line.	III. DO NOT GIT	er the mot	de or dyli	ig, sucii as	s cardiac of	i i espiratory a	arrest.			Interval Between Onset and Death	
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	۾	Part II. Other significant condition			_	inderlying (	cause giv	en in Part	I.						
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	ŧ	4 ☐ Homicide deter		ace of Injury - At h ilding, etc. <i>(Spec</i> i		reet, ractor	ry, once		1	City or To	wn, State	9)	007 07 111	brar rioble reprioer.	
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	Medical Certification: To	(Check only 2 Medica one)	Examiner: On the and m	e basis of examin anner stated.	ation and/or in	vestigation	ii, iii my (	риноп, аө	au uccurre	ou at the time	, uate an	u piace,	and due	e to the cause(s)	
							c. Licens	se number			29d. Da	te signe	ed (Mont	th, Day, Year)	
		1 -30D21	6				DY	1032	24		Nev	EMI	BER	25,2006	
									•					,-	
		30. Name and address of person	who completed c	ause of death (Ite	m 23a) (Type,	Print)	4.5			14 401	11.0		2 -	3	
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			Hegistrer     Decedent's Name (First, Middle 1)	e, Last)				, oatir		Date of Deat			e ol Death
	Physicia /Medic		Nellie	La	wton					11/ 2	$2^{\frac{7}{6}} 2006$	6:5	0 A M
	Examin		4a. Fecility Name (If not institution					Location of			4c. County of I		
			3604 Willow I					rille			Prince Georges		
	Funeral		5. Social Security Number		e (In yrs. last birti 98	hday) If Under 1 Months	Days	If Under 2 Hours	Min.	Date of Birth (Month, Day,		. Birthplace (Sta Country)	
	Director		578-26-4387 Usuel Residence of Decedent		70					1/25/	1907 G	eorgia	
	yland how		10a. State 10b. County		10c. City, Town	or Location							e City Limits
	atter death with the Marylan or Iteme 23a or 28a-f show uniner must be notified at	Director	MD Princ	ce Georges	Fores	tville							res 2□No
	or 28	Dire	10e. Street and Number			10f. Zip (				1	0g. Citizen of Wha	•	
	ath w	ra	3604 Willow			207			in? (Canada	Ven es No	U.S.	American Indian	
	Item Item	Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Mar	12. Was Decedent Armed Forces?		13. Was Decede If Yes, speci	fy Cubar	n, Mexican,	, Puerto Ric	an, etc.)		White, etc.	
336	hours atter death with the Maryland ture!, or Iteme 23s or 28s-f ehow at Examinat must be notified at	by	3 Widowed 4 □ Divorced	If Yes Give		1 ☐ Yes 2	<b>□</b> No	Specify:			Specify:	Black	:
21215-0036	72 hou	Completed	15. Deceder	nt's Education est grade completed)	16a.	Decedent's Usual (Give kind of work life. DO NOT use	Occupa	tion	of working		16b. Kind of Busin	ness/industry	
21	within 7 ene. then 'r	nple	Elementary/Secondary (0-12)	College (1-4or 5		Domesti		uning moor	o,g		Privat	o.	
	Hygier Hygier Sther th		17. Father's Name (First, Middle,	( ant)		Domesci		19 Mother	r's Name /F	iret Middle I	Maiden Sumame)	<u> </u>	
Maryland	Z in D ≥	To Be		nandler					rie		ill		
JZ.	should and Mer ie marke	Ě	19a. tnformant's Name/Relations	ship (Type, Print)	19b.	. Mailing Address	(Street a				r, City or Town, Sta	ate, Zip Code)	
	コモトコ		Rodney Jordan	n/Great nep	hew 36	04 Will	OW	Ridg	ge Ct	.Fore	stville	,MD 20	747
ore	ges 1 and t of Healt If item 2 or other		20a. Method of Disposition 1x☐ Burial 2 ☐ Cremation	3 □Removal from State	cemeter	Disposition (Nam y, crematory or ot	her place		Date		20c. Location - Cit		
Ĕ	artment of ortant: If it injury or o		4 Donation 5 Other (		MD Na	tional			2/02		Laurel		
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service	1722 N	.Ca	pito	ol St	.NW W	Funera ashingt				
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications, that caused t only one of is on each li	the death. Do n	tot enter the mode	of dying	, such as	caldiac of the	aspiratory arm	est,	Approxi	mate Between nd Death
	Physician		Immediate Cause (Final disease or condition	. Hw	le	OWN	a	O D	<u> </u>	TOW	HICCOO	NE	cent
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	(1)	21-				OFF	MAT C
		Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence	of):	V	\ \ \ \ \		_		CIM	Thirt -
	uted d ansit	Examiner	cause. Enter Underlying Causs (Disease of injury that initiated events	1 00	ROOM	PRZY	+	1K	IZV	el !	DISCASI	C CH	24005
ó	be executed sicien and burial-transit		resulting in death) Last	Due to (or as	a consequence	of):							
3760,	# × #	llcal		d		· · · · · · · · · · · · · · · · · · ·						- 1	
x 68	eath certificat ettending phy I for use as the	/Mec	IF FEMALE:	23c. If yes, outcome	of pregnancy						024 Date 6	A delice	
Вох	ettend for us	lan	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐Ectopic pre 5 ☐ Other (spe					23d. Date of Month		Year
P.O.	that the de ned by the e detached f	Physiclan/Med	1 ☐ Yes 2 🙀 No 9 ☐ Unknown	9□ Unknown		0 23 0 11 10 19 10							
	res that igned b be deta	by Pt	Part II Other significant condit	ions contributing to death b	out not resulting in	the underlying ca	use give	en in Part I.		23e. Did to	bacco use contribu	ute to the cause	of death?
rd	w require been sig should b	led t	CHICON	TO DIE	en en	717	7			1 🗆 Y	es 2 □ No 3 (	Probably 4	Mul
Records,	a S.C.I	Completed	- BKENN	SHOH	148	144N	H			24a. Was a autops	sy prio	re autopsy findir or to completion	ngs available of cause of
<u>~</u>		Con								performula 1 Yes		ath? ]Yes 2₩ No	
Vital	Physician: The this certificete rat director, page	Be	25. Was case referred to medic examiner?	Managinal.			Othe	NP.		Check only or			
of	Phys rthis rat dii	5	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inju		itpatient 3 DO	Bc. Injury Work	4 🗆 Nu			ence 6 Other ow injury occurred		
on	th. : After e funera	tior	1 Natural 5 Pend	ing (Month, Da tigation	i <i>y Year)</i> li	njury M		:? ∕es 2—∏i	No				
Division	er dea	Certification:	3 ☐ Suicide 6 ☐ Could	minor ZOB. Flaue UI III	jury - At home, la	rm, street, lactory	, office		281	. Location (S. City or Town	treet and Number n, State)	or Rural Route I	Number,
ā	ital or irs aft rei Dir led in				10								
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical		ing Physician: To the best I Examiner: On the basis of and manner st	of examination an								se(s)
<b>\</b>		Σ	29b. Signature and title of certific	er Wallo	· ~ M	290	License	number 72	20	2	29d Date signed (	Month Day, Yea	rc)
	AC.		Somooby	MARINI	a IIV	7 1	1	1771	7		1110	010	0
	(7)		1100 1	who completed cause of a	SIK	E E T	N	W	360	DN,	MABH	WOTWE.	VC20010
	Sta Regist	ate rar	31. Date filed (Month, Day, Year NOV 29 2006	Sauce 32. Hegisti	rar's Synature						·		

		1	State of Maryland / Department of Health and  1- State  Certificate of Death		2000	39854
			Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Death	g. No.	3. Time of Death
	Physicia /Medic	ın	Barbara L. Larrimore	Month	19 2006	0925 M
	Examin	_	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De	eath	4c. County of Deat	h
			Anne Arundel Gen Hosp Annapolie	5	AA	/O+ + F
	Funeral			8. Date of Birth (Month, Day, Apr. 1,	Year) 9. Bin	hplace (State or Foreign untry)  NE
	Director	-	506-40-5607 1	Apr. 1,	1233	1417
	and	<b>—</b>	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary f sho	ō	MD Anne Arundel Gambrills			1 □ Yes 2 No
	28e	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	untry?
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther then "natural", or items 23e or 28e-f show do ther then "natural", or items 23e or 28e-f show event, the Medical Examinar must be notified at				USA	
	death	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Po	(Specify Yes or No-	14. Race - Ame Black, Whit	
9	after or fte			,		<i>h</i> ite
8	rel,	dby	3 Widowed 4 Divorced Year or Dates:			
ر ا	72 h	ete	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of life, DO NOT use retired)	working	16b. Kind of Business	industry -
12	hen hen	Completed	Elementary/Secondary (0-12)  College (1-4or 5+)  Disability Speciali	lst	Federal Go	overnment
5	iled v tygie ther t			Name (First, Middle, N	faiden Sumame)	
Maryland 21215-0036	d fall	o Be	Donot De la Company	hy I. Rich	ardson	
<u> </u>	2 should be and Mental Is marked o	은	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of			Zip Code)
	nd 2 lith a 27 is r freu		William Larrimore/Husband 1509 Branchwood Ter	rrace, Gamb	rills, MD	21054
ē,	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or	
Ê	Pages nent of nnt: If it		1⊠ Burial 2 □ Cremation 3 □ Removal from State  1	<sup>10v</sup> 2006	Davidson	ville, MD
Baltimore,	permit. Pages Department of I Importent: If it any Injury or o		21. Signature of Lundral Service Licensee  22. Name and Address of Facility Barranco & Sons, 495 Gov. Ritchie	P.A. Sever	na Park Fu na Park, N	uenral Home MD 21146
			23a Part 1. Enter the disease, or complications that caosed the death. Do not enter the mode of dying, such as car			Approximate Interval Between
	Observation		shock, or heart failure. List only one caus- on each line.  Immediate Cause (Final disease or condition a. House Cavalac Tusuff Cavalac Tusuf	510 10 11	,	Onset and Death
	Pnysician /Medical		disease or condition resulting in death)  a. The disease or condition a. Due to (or as a consequence of):	TETEBE	1	
	Examiner		b. Hypevolemia			
	D :=	ner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying			
	ocute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit					
687	cate b	dicai				
9 x	ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	livery
Вох	attendatter	Physician/Med	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?  4 Pregnant at time of death 5 Other (specify)		Month	Day Year
o.	the de	ysic	1 ☐ Yes 2 No 9 ☐ Unknown			
<u>α</u>	res that the de igned by the a be detached t			23e. Did tot	oacco use contribute t	the cause of death?
Sp	uires sign lid be	d by		1 □ Ye	es 2□No 3□P	robably 4 Unknown
Records,	w requir been si should	Completed		24a. Was a	n 24b. Were a	utopsy findings available completion of cause of
Re	he law e has age 2 s	Juc		autops perform 1 ☐ Yes 2	med? death? 2∑No 1 ☐ Yes	
Vital		O.	25. Was case referred to medical 26. Place of	Death Check onl on	, ,	
>	Physicien: r this certific ral director,	To B	examiner? Other	ng Home 5 Reside	ence 6 Other (Spe	ecify)
of	g Physier this			28d. Describe ho	ow injury occurred	
Ö	Attending r death.	atio	1 Natural 5 Pending (Month, Day 16a) Injury  2 Accident investigation M 1 Yes 2 No			
Division	r Atte	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St City or Town	reet and Number or A n, State)	ural Route Number,
	itel o irs aft rel Di	Se		land and the to the o		e atotod
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and part of the basis of examination and/or investigation, in my opinion, death and manner stated.	occurred at the time, d	ate and place, and du	e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number		9d. Date signed (Mon	
)			Millia J. po , ma DO603	7	11/22/0	<b>P</b>
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  William P. Janes, M.D. 695 Ame	- 4	1 03	
_	10			rick di	050	
	St. Regist	ate				
		051	NOV 2 7 2006 Assess As Acadh			

			For State	State of I	Maryland		artment of H		and Mental H	Hygien Reg. N	200	6	39855
			Registrar  1. Decedent's Name (First, Middle, Last	t)			Timoato or i	Jeann	2. Date of		0	0	. Time of Death
	Physicia		ROBERT	_	LEE		Sr		Month Decer		9,20	ear 06	11:00P <sup>M</sup>
	/Medic Examin	_	4a. Facility Name (If not institution, give	street and numb	er)		4b. City, Town, or	Location of			c. County of		
			Frederick Memo				Frederi				Frede		
	Funeral Director		5. Social Security Number 6. Se 212–24–3317	ex 7. XMM 2□F	Age (In yrs. Id	7 Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Date of (Month) Apr 1	Day, Yea.	5)00	Birthplace Country) Mary L	e (State or Foreign and
	put		Usual Residence of Decedent  10a, State 10b, County		10c. City	, Town or Lo	ocation					10d.	Inside City Limits
	Aaryla F shoved at	5	Maryland Frederi	ck		Frede							1 ☐ Yes 2 📉 No
	the N 28a- notifi	rect	10e. Street and Number				10f. Zip Code			10g. C	itizen of Wha	at Country?	>
	th with 23a or ust be	alD	7605 Green Valley	7 Road				L <b>7</b> 01			U.S.A		
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	es? <b>∑</b> No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes ※ No	lispanic Ori an, Mexicar Specify:	gin? (Specify Yes o n, Puerto Rican, etc.	No-	14. Race - Black, Specify:	American i White, etc. Whit	
200	72 hol natura Jical E	Completed	15. Decedent's Edi (Specify only highest grad			16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during mos	t of working	16b.	Kind of Busir	ess/indust	try
2	vithin 'ne. han "	mple	Elementary/Secondary (0-12)	College (1-4	or 5+)	Mast	po not use retired er Carper	nter			Constr	uctio	n
וא ס	filed v Hygie ther t		17. Father's Name (First, Middle, Last)					18. Mothe	er's Name (First, Mid	Idle, Maide	en Surname)		
an	Mental Mental arked o	To Be		ebster	Lee			Ma	argaret	Seli:	na E	ckenr	ode
Maryland 21215-0036	nd 2 should Ith and Men 27 is marke traumatic	-	19a. informant's Name/Relationship (7 Betty Fogle Lee,						er or Rural Route Nu Road, Fre	-			
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		oto Ci	emetery, cre	osition (Name of ematory or other place on Mem Gar		Date Dec 13,20		Location - Cit Freder	-	
Baltir	permit. P Departme Importan any injur.		21. Signature of Funeral Service Licen		7	2	2. Name and Addre	ss of Facili	ord P.A.	Fune:	ral Ho	me	
			23a, Fart I. Enter the disease, or comp	polications that cau	MOQ7(				St. Fred		k, Mar	- Ac	proximate
	Physician		shock, or heart failere. List only of immediate Cause (Final	one cause on eac	th line.		RY FAT					Int Or	terval Between
	/Medical		disease or condition resulting in death)	D 4 / a									weeks
	Examiner		Conventially list conditions	METH	STATIC	NOW	-SMALL	CELL	LUNG G	ANCE	R	/	YEAR
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	uence of):							
V	ecute and I-trans	Examine	that initiated events resulting in death) Last	c	as a consequ	uence of):							
8760,	cate be executed oblysician and the burial-transit		l	d									
687	ficate p physis the	edical		,0									
.O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as it	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 Feta	death 3	□Ectopic pregnanc □ Other (specify) _	у		_	23d. Date of Month	,	y Year
<u>α</u>	w requires that the debeen signed by the should be detached		Part II. Other significant conditions of	_	_	ılting in the	undertying cause giv	en in Part I	I. 23e. [	oid tobacco	o use contrib	ute to the c	cause of death?
rds	quires en sign uld be	q pa	CONGESTIVE HEAD	T FAIL	URE					Yes	2 □ No 3	☐ Probabl	y 4 □Unknown
Records,	law re as bee 2 sho	Completed by	CHRENIC BENAL CORENAPY ARTE	FAILUR	E					Vas an iutopsy	24b. We	re autopsy	findings available etion of cause of
	The ate har page	Com	CORENAPY ARTE	RY DISE	ASE				10 Y	erformed?	dea	ith?	□No
/ita	Physician: r this certific ral director,	Be (	25. Was case referred to medical examiner?	Linealiali			Lou		e of Death (Check o	nly one)			
Or	Physical this call dire	은	1 ☐ Yes 2 No  27. Manner of Death	Hospital: 1 Inc		ER/Outpatie		4 L N	ursing Home 5 1		6 □Other		
uc	ding l After funer	ion:	1 Natural 5 ☐ Pending	(Month,	Day Year)	Injury	Wor	rk? ∣Yes 2□		ibe now in	jury occurred		
Division or Vital	for Attending Physician: The law after death. Director: After this certificate has in by the funeral director, page 2.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	f injury - At ho g, etc. <i>(Sp</i> ec <i>if</i> )		treet, factory, office		28f. Locati	on (Street or Town, Sta	and Number ate)	or Rural R	oute Number,
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce			is of examina				nd place, and due to ath occurred at the t				
<b>\</b>	To the within To the compl	Me	29b. Signature and title of certifier	Connor	Mo		29c. Licens	176	/	1	2-///	06	
7	01		30. Name and address of person who BRIAN M. O Con 31. Date filed (Month, Day, Year)	completed cause	of death (Item	1 23a) (Type	Print)	ST.	FREBEN	rick	MO	217	01
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	6 Reg	gistrar's Signa	ture Sos	The same	,	/	,	,		
	-		DFQ T # 100	· Julier									

DHMH 17 Rev 1/2001

	1- For Amend #5 Per Registrar	FH <b>State</b> 95/437	yland / Depa Ce	artment of F	lealth and Death		giene 0	06	39856			
Physician /Medical		eriscilla	Lee			2. Date of De Decembe	er 7, 20	)ď&°	3:00 pmM			
Examiner Funeral	4a. Facility Name (If not institution, given Glade Valley No.	ursing Cente	er In yrs. last birthday)	If Under 1 Year	rsville	rs. 8 Date of Bird	h	eder	ick			
Director	215-74-6 <del>879</del> Usual Residence of Decedent		82 Yrs.	Months Days	Hours M	Dec 21	, 1923	Minn	place (State or Foreign ntry) 1esota			
e Marylan a-f ehow utiled at	Maryland Freder		oc. City, Town or Lo Wa1ker	sville					10d. Inside City Limits 1 X Yes 2 □ No			
of the death with the Mar if theme 23s or 28s-1 of the mouthled when must be notified.	10e. Street and Number 56 West Frederic	k Street		10f. Zip Code 2179	93		10g. Citizen of U.S		ntry?			
pointing in the plant of the land of the land of the many and permit. Pages 1 and 2 should be lifed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-fehow amy fulury or other traumatic event, the Medical Estimat must be notified at once.  To Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 □ Yes 2 ঐNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		ce - Americk, White,	etc.			
Maily falled within 72 hours aff of 2 should be filed within 72 hours aff ith and Mantal Hygiene. 27 is marked other than "natural, or traumatic event, the Madical Farm To Be Completed by F	15. Decedent's E (Specify only highest gr.	ducation ade <i>completed</i> ) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Ver Worke	during most of v	vorking	16b. Kind of B	lusiness/In	dustry			
Mental Hy arked other atto event,	17. Father's Name (First, Middle, Last		Lee		18. Mother's N	ame (First, Middle, Pear			ers			
nd 2 short and half hand half hand half hand half trauma	19a. Informant's Name/Relationship (		ster 870	ng Address (Street 1 S Ko1b	and Number or Rd, Tuc	Rural Route Numberson, Ari	er, City or Town zona 8	, <i>State, Zip</i> 5 <i>7</i> 06	, Code)			
Dalilliole, bemit. Pages 1 at Department of Hee mportant: If Item ny injury or othan one.		Removal from State	cemetery, crei	matory or other place	· 1	Date 8. 2006		-				
Departm Departm Importate any inju	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Smithsburg Crematory Dec 8, 2006 Smithsburg,  21. Signature of Funeral Service Licensee  MO0706  Smithsburg Crematory Dec 8, 2006 Smithsburg,  Reeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Marylar  23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.											
Physician /Medical	23a. Parti. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line.	e death. Do not ent Gastroint	er the mode of dyin	ng, such as card	ac or respiratory ai	rrest.	11.91(1	Approximate Interval Between Onset and Death Weeks			
porou, rate be executed xm by sicien and mith burial-transit unit dical Examiner		Due to (or as a c							Years			
death certific	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2X No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 { 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,			ite of deliver	ery Day Year			
	Dementia	contributing to death but r	not resulting in the u	nderlying cause giv	en in Part I.		obacco use con res 2 🗷 No		he cause of death?			
						24a. Was autor perio 1 🗆 Yes	osy rmed?		opsy findings available impletion of cause of			
Physician: The Physician: The The Co. To Be Co.	examiner? 1 ☐ Yes 2 🕅 No	Hospital:	2 ER/Outpatier	nt 3□ DOA Oth	er	eath (Check only on the second of the secon		ner (Specif				
Attending Phy r death. T death. Setor: After this by the funeral of the funeral o		28a. Date of Injury (Month, Day Y	28b. Time o	f 28c. Injur Wor	y at	_	now injury occur		,,			
DIVISION of tall or Attending F is after death. ei Director: After ed in by the funergent in by the funerg	3 Suicide 6 Could not to 4 Homicide determined		- At home, farm, str (Specify)	reet, factory, office		28f. Location (S City or Tox		ber or Rura	al Route Number,			
To the Hospital or Atti within 24 hours after de To the Funerel Directi completely filled in by It		hysician: To the best of miner: On the basis of example and manner stated	camination and/or in	h occurred at the tir vestigation, in my o	ne, date and pla pinion, death or	ce, and due to the curred at the time,	cause(s) and m date and place.	anner as s and due to	tated. o the cause(s)			
To the To the comp	29b. Signature and title of certifier			29c. Licens	e number .6516		29d. Date signe					
	30. Name and address of person who Allen Gilson, M.	completed cause of deat D., 1475 Ta	th (Item 23a) (Type, ney Avenu	Print)		rederick,	Decemb Maryla					
State Registrar	31. Date filed (Month, Day, Year)	20 Decistre de										

## 06-09187

# Please Type or Print in Black Indelible Ink

David Lancaster	1- For State Registrar	ate of Maryland	•	e of Death	id ivientai n		g No. 200	6 3985
Physician/ Medical Examine	1. Decedent's Name (First, Midd	yne Lancas	tor			2. Date of Death Month December	h	3. Time of Death 0431 hrs
wedicai Examme	4a Facility Name (if not institution			4b. City, Town, o	r Location of Death		3, 2006 4c. County of Deat	
	Garrett County Memo			Oakland			Garrett	
Funeral Director	5. Social Security Number 203-48-6609		ge (In yrs last birthd	ay) If Under 1 Ye  Months Da			Forei	rthplace (State or gn PA
any .	Usual Residence of Decedent  10a. State  10b. County		10c. City, Town or	Location				10d. Inside City Limits
Varyland 28a-f show any d at once,	MD Garı	ett	0ak1a	nd				1 X Yes 2 No
the Maryland a or 28a-f sh iified at once Director	10e. Street and Number			10f. Zip Code		10	g Citizen of What Cou	intry?
ith the 23a or notific		12. Was Deceden	Ever in U.S. 1	3. Was Decedent of H	1550	pocify Vos or No.	USA	ican Indian, Black,
r death with or items 23 must be no	1 Never Married 2 N	arried Armed Forces		If Yes, specify Cuba			White, etc.	ican indian, black,
after dann, or iner m		vorced If Yes, Give Year or Dates:		1 Yes 2 X N				hite
5-0036 ed within 72 hours aft ed within 72 hours aft other than "natural" he Medical Examine Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)		du	cedent's Usual Occupa ring most of working lif			16b. Kind of Business	(Industry
336 thin 72 than than edical	12	oonege (1 4 or	·	ter Diesel	Technic	ian	Automobi	1ė
5-0( lled with Hygier 1 other the M			I			e (First, Middle, M	laiden Surname)	
2121: ald be fil Mental B marked event,			19b.	Mailing Address (Stre	Bertha eet and Number or		ber, City or Town, State	- Zip Code)
MD 2 shou h and h and the sum aftic	Bertha Hale-0			Gorman St				, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
nore, MD 21215-0036  ages 1 and 2 should be filed within 72 hours after death with the Maryland  to f Health and Mental Hygene  t: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Evaminer must be notified at once.  To Be Completed by Funeral Director	20a. Method of Disposition  1 Burial 2 X Cremation	n 3 Removal from Si	cremator	Disposition (Name of co or other place)		Date	20c. Location - City of	
Page:	4 Donation 5 Other S	pecify	Countr	••		/08/2006	Davidsvi1	1e, PA
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	21 Signature of Funer Service	e icensee		22. Name and Address Humbert Fu	-	me, Conf	fluence, PA	15424
Physician /Medical	23a. Part I Enter the diseas, o failure. List only one ause	e on each line.		enter the mode of dying	g, such as cardiac o	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Examiner	Immediate Cause (Final diseas or condition resulting in death)	a. Multiple Gunsh  Due to (or as a cons						Death
Page - P	Sequentially list conditions,	b						
in a single	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence of):					
uted ansit	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):					
cords, P.O. Box 68760,  Iaw requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - transi	UNPENDED	d AMENDED						
760, cate be physic the bur	IF FEMALE:	23c If yes, outco	me of pregnancy				23d Date of deliver	1
certification ce	23b. Was decedent pregnant in past 12 months?	Live birti	2 t time of death 5	Fetal death 3 Other (Specify)	Ectopic pregn	ancy	Month	Day Year
). Box 687 the death certific the attending; ched for use as t Physician/	1 Yes 2 No 9 Ur	uknown 9 Unknown						
P.O.		tions contributing to dea	th but not resulting i	n the underlying cause	given in Part I.		bacco use contribute to	
dS, lequires een sig						24a Was a	an 24b. Were a	utopsy findings available
Records, The law require. ficate has been signage 2 should be.	ļ <u></u>					autops perfor 1 Ves 2	med? death?	completion of cause of
n: The ritificat tor, pag		al		26.Plac	ce of Death (Check		2 No 1 Y	es 2 No
of Vital Records ing Physician: The law requi After this certificate has been uneral director, page 2 should	1 ✓ Yes 2 No		ent 2 🗸 ER/Outp				Residence 6 Othe	or:
	27. Manner of Death  1 Natural 5 Per	28a Date of Inj (Month Day Dec 3, 2006	ury 28b. Tir Year) 0218 I		ury at Work? Yes 2 🗸 No	28d Describe h Subject shot	now injury occurred	
ViSi or Att or Att or Att in by t in by t	2 Accident Inve	ild not be	njury - At home, farr	n, street, factory, office	building, etc.	28f. Location (S or Town, St		ural Route Number, City
Di hours a filled			ngle Family Ho			1111 Accident	Fríendsville, Accide	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the best of naminer: On the basis of examiner stated	amination and/or inv					
F » F S S	29b Signature and title of certif				nse number		29d. Date signed (Mo	
		1_1_		0.0	.M.E.		December 3, 20	06
H	30. Name and add ss of per-	n the comete sus of Deputy Chief Med		111 Penn Stree	et, Baltimore, N	MD 21201		
Stat Registra	1 ( ) 1	4 2006 32 Tegistr	ar's Signature	Gorle				
Negistia								

06-08116 Nancy Lipinski

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 39858

		For State		Certi	ficate of	Death			Re	g. No		
Physician/		egistrar . Decedent's Name (First, Middle,Last)	·····				***		2. Date of Deat Month		or.	3. Time of Death
Medical Examine	r	NANCY MALTMA	AN L	IPINS	KI				October 2	B, 2006		1201 hrs
	4	a. Facility Name (if not institution, give 197 Hollingsworth Manor	street and number)		41	b. City, Town <b>Elkton</b>	, or Location	of Death		4c. County Cecil	of Death	
Funeral	5	. Social Security Number 6. Sex	7. Age (	In yrs. last	birthday)	If Under 1		ler 24Hrs.	8. Date of Bir	th(MM/DD/YYY	Y) 9 Birti Foreigi	nplace (State or
Director	L		и 2 <mark>X</mark> F	50	Yrs.	Months [	Days Hour	s Min.	MAY 3	1, 1956		intry) DE
any	_	Usual Residence of Decedent  Oa. State 10b. County	11	Oc. City, To	own or Location	on						10d Inside City Limits
<b>*</b>	1	MD CECIL			ELKTON							1 Yes 2 X No
Aaryland 28a-f show 1 at once.		0e. Street and Number	J			10f. Zip Coo	le		11	Og. Citizen of W	hat Coun	try?
ith the Maryland 23a or 28a-f sho notified at once		197 HOLLINGSWORTH	H MANOR			2192	21			USA		
e, MD 21215-0036  I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygene. I tem 27 is marked other than "natural", or items 23a or 28a-f shur traumatic event, the Medical Examiner must be notified at once	1	Marital Status     Never Married 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2 X	ver in U.S. X No		Becedent of es, specify Cu			ecify Yes or No Rican, etc.)		e - Amerio te, etc.	can Indian, Black,
fier d		3 Widowed 4 XXDivorced		V MO	1	Yes 2X	No specify	y:		Specify:	W	HITE
ours aft.		15. Decedent's Education (Specify only		leted) 1	6a. Decedent	's Usual Occ				16b. Kind of B	lusiness/li	ndustry
5-0036 ed within 72 hour lygiene. other than "natu		Elementary/Secondary (0-12)	College (1-4 or 5+	)	HOMEMA				,	HER 1	HOME	
215-0036 be filed within 72 ntal Hygiene. Red other than ent, the Medical	<u>5</u>  -	7. Father's Name (First, Middle, Last)					18.Mothe	er's Name	(First, Middle, I	Maiden Surnam		
21216 uld be fill Mental H marked c event, 1		ELLWOOD MALTMAN							NE LEOI			
Should I should I is mar matic even	2 [⁻	9a. Informant's Name/Relationship (Ty								nber, City or To	wn, State,	Zip Code)
e, MD I and 2 sho Health and Health and refraumati		ELIZABETH R. LI	PINSKI	20b Pt	2811 ace of Disposi			TOKAN	IE, WA	99223 20c. Location	- City or	Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 XXCremation 3	Removal from State						BER 31			TON DE
Baltimo		4 Donation 5 Other Specify:			SERVICE	S ame and Add	lrose of Earil		006	WIL	MING	TON, DE
Baltimor permit. Pages I Department of I Important: If injury or other	1	21. Signature of Funeral Sorvice Licens	IR N-00	178/	I ME	CALEY 1	FUNERA	L HON	ES	DE 1000	_	
Physician	1	CHARLES F. MEALEY 3a Part I. Enter the disease, or compli	cations that caused the	ne death. [	Do not enter th	e mode of dy	ing, such as	cardiac or	respiratory arr	DE 1980 est, shock, or h	eart	Approximate Interval Between Onset and
/Medical	١	failure. List only one cause on eac Immediate Cause (Final disease a. [	n ine. Doxepin intoxicat	tion								Death
Examiner			oue to (or as a consec	quence of):								
	_		Oue to (or as a consec	quence of):								
\	Εļ	cause. Enter Underlying Cause (Disease or injury that initiated	oue to (or as a consec	illence of).							_	
uted id ransit	Ĭ	events resulting in death) Last L d.		401100 017								
760, icate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED									
760, ficate be g physic s the bur	<b>E</b> 2	IF FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcome	e of pregna		tal death	3 Ecto	pic pregna	ncy	23d. Date of Month		) Day Year
Box 687 e death certific the attending p ed for use as th	Physician	past 12 months?	4 Pregnant at t	ime of	- =	her (Specify)						
Box ne death the atte	<u>Ş</u>	1 Yes 2 No 9 V Unknown	9 Unknown	h. 4	ulting in the u	ndorlying on	ico given in	Port I	23e Didt	nhacco use con	tribute to	the cause of death?
cords, P.O. Box 687 law requires that the death certific has been signed by the attending.	2	Part II. Other significant conditions	contributing to death	but not res	salang in the c	inderlying car	ase given in	att.				pably 4 🗸 Unknown
ords, w require us been si should b	Completed								24a. Was		. Were au	topsy findings available completion of cause of
Recor The law r icate has t	힑								autoj perfo 1 <b>V</b> Yes	rmed?	death?	
I. Re uifficati uifficati		25. Was case referred to medical				26.	Place of Deal	th (Check		2		2 1
Vital   ysician:	8 B		ospital: 1 Inpatier	nt 2 🔲 E	ER/Outpatient	3 DOA	Other <sub>4</sub>	Nursin	g Home 5	Residence 6	<b>✓</b> Other	: Scene
of Vital Records ing Physician: The law requ After this certificate has been uneral director, page 2 should		27. Manner of Death	28a. Date of Injur (Month, Day,Ye	y ear)	28b. Time of I	njury 28c	Injury at Wo	ork?	28d. Describe Subject too	how injury occu	ırred	
ion tendii tor: /	흷	1 Natural 5 Pending 2 Accident Investigation	0+100 2006		FOUND: 1156 hrs	1	Yes 2	<b>V</b> No				
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that twithin 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detacompletely filled in by the funeral director, page 2 should be detacompletely filled in by the funeral director, page 2 should be detacompletely filled in by the funeral director, page 2 should be detacompletely filled in by the funeral director, page 2 should be detacompletely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju	-		et, factory, of	fice building,	etc.	or Town			ral Route Number, City
hou hou y fill		29a. Certifier	(Specify) Sing			rred at the tin	ne date and	place and				
To the H within 24 To the Fu	Medical		On the basis of exan	nination an	d/or investigation	tion, in my op	inion, death	occurred a	t the time, date	and place, and	due to th	e cause(s)
To To con	ğ	29b. Signature and title of pertition	and manner stated		<del></del>	29c. L	icense numb	er	**	29d Date sig	gned (Mo	nth, Day Year)
		4//				0	D.C.M.E.			October 2	29, 200	6
_	-	30. Name and address of person who	•									
		Theodore M. King, Jr., MD				111 Peni	Street, E	Baltimor	e, MD 2120	7		
Sta Registr	1.0	31. Date filed (Month, Day Year)	32 Registrar	's Signatur	· Chara	200						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes and Copies Are Legible.

		•	1- State of Maryland / Department of Health Certificate of Death		tai Hygier Reg. i	/ HUb	39859
i	Physicia		1. Decedent's Name (First, Middle, Last)  Marlene Jean Miller	N		Day Year 2006	3. Time of Death 1805 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location			4c. County of Deat	
			MEMORIAL HOSPITAL  5. Social Security Number   16. Sex   7. Age (In vrs. last birthday)   If Under 1 Year   If Under 1 Y	der 24 Hrs. 8 D	-Af Dist	ALLEGANY	
	Funeral Director		217-74-9728 1 M 200 70 Yrs. Months Days Hours	rs Min. (A	ept. 27	1936 Mar	hplace (State or Foreign ountry) <b>yland</b>
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryl -f sho fied a	tor	MD. Allegany Cumberland				1 □ Yes 2 No
	n with the 3a or 28a st be noti	Funeral Director	10e. Street and Number 13012 McMullen Highway Apt. B 10f. Zip Code 21502			Citizen of What Co nited Sta	
980	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 ☑ Was Decedent Ever in U.S. Armed Forces?  1 ☑ Wever Married 2 ☐ Married		Yes or No- n, etc.)	14. Race - Ame Black, Whit Specifyhit	e, etc.
Maryland 21215-0036	within 72 h lene. than "natu he Medical	Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  Unknown  16a. Decedent's Usual Occupation (Give kind of work done during m life. DO NOT use retired)  never worked	most of working	16b.	. Kind of Business/	
land 5	should be filed od Mental Hygi marked other matic event, ti	To Be Co	17. Father's Name (First, Middle, Last)  18. Mot	other's Name (Firs Kathleer			
, Mary	and 2 shou alth and M 27 Is mar er traumat	-	19a. Informant's Name/Relationship (Type. Print)  William Miller/ brother  19b. Mailing Address (Street and Num 5 East Hanekamp				
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 Is marked any Injury or other traumatic evonce.		20a. Method of Disposition  1 ☐ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Philos Cemetery	12/06/ 2006	' Wes	~	Town, State , Maryland
Balt	permit. Departr Importa any Inje		21. Signature of Funeral Service Licensee  7. Nay Service Licensee 111 Church St	<sup>acility</sup> Boal F , Wester	mport,		1 21562
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  _a. A SPIRATION PNEUM DIV		piratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)  A SPIRATION YNEUM DIVIDING TO THE CONTROL OF THE CONTR	INI /T			3 1173
	o. tis	iner	Sequentially list conditions, from Long Long Long Long Long Long Long Long				
60,	ificate be executed g physician and as the burial-transit	al Examiner	that initiated events resulting in death) Last				
68760,	g phys	edical	d				
P.O. Box	ath cert attending for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □			23d. Date of del Month	ivery Day Year
rds, P	N requires that the deben signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part S & VAMOUS CELL CARCINOMA DF LIPS	art I.	23e. Did tobacc		o the cause of death?
Vital Records,	rsiclan: The law rec s certificate has bee lirector, page 2 shou	Completed by			24a. Was an autopsy performed 1□ Yes 2	prior to death?	utopsy findings available completion of cause of
Ita	slan: ertifica ctor, p	Be C	examiner?	lace of Death (Che		10 100	
2	Physic this co	은	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐			6 □Other (Spe	cify)
OU (	ttending Phydeath. Stor: After thi	tion:	1 Natural 5 Pending (Month, Day Year) Injury Work?		Describe how ir	njury occurred	
Division or	ul or Attending Physiclan: after death. I Director: After this certifica d in by the funeral director. I	Certification:	2   Accident investigation 3	28f. L	ocation (Street City or Town, St	and Number or Relate)	ural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, of and manner stated.				
	To the To the Comp	M	29b. Signature and title of certifier  29c. License numbe	per		Date signed (Mont	
			M.D. D63118		(2	02 -	2006
		ર	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  WIRASAT HASNAIN, M.D. 900 SETON DRIVE CUMBERLAND	o, MD 215	502		
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Regist	ar	DEC - 4 2006 France & April				

		•	State of Maryland / Department of Health are State of Pertificate of Death		Reg. No. 2006	39860
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Margie L. McCormick	2. Date of D Month Nover	Day Year	3. Time of Death
	Examin		4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Berlin Nursing & Rehabilitation Ctr. Berlin		4c. County of Deal	
	Funeral Director		5. Social Security Number  181-18-7737  6. Sex 1 Months Days Hours 83  7. Age (In yrs. last birthday) 4. Months Days Hours	Min. 8. Date of E	Birth (Co. Co. Co. Co. Co. Co. Co. Co. Co. Co.	hplace (State or Foreign buntry) t Virginia
	yland		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. fnside City Limits
	the Mar	Director	MD Worcester Ocean Pines  10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	1 Tyes 2 No
	h with	a D	12 Beach Court 21811		USA	
. L.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked othar than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Madical Exercises must be notified a one.	by Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2XXNo If Yes, Give Year or Dates:	in? (Specify Yes or i Puerto Rican, etc.)	No- 14. Race - Ame Black, Whit Specify: Wh	e, etc.
rgaret L <b>21215-0036</b>	vithin 72 hounder.	Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  Homemaker	of working	16b. Kind of Business.  Own Home	
Mar	Hygie othar t	e Co		's Name (First, Midd	lle, Maiden Sumame)	-
a	Menta Menta arked atic ev	To B		ise Kempe		
McCormick, Saltimore, Maryl	nd 2 shall the and 27 is m		19a. Informant's Name/Refationship (Type, Print)  Dianne Teslovich  19b. Mailing Address (Street and Number)  12 Beach Court, 06			Zip Code)
McCormi Baltimore,	of Head		20a. Method of Disposition  1  Burial 2 XCremation 3 Removal from State	Date	20c. Location - City or	
E CC	it. Pag intment intant: njury c	4	4 Donation 5 Other (Specify)  21. Signature of Funeral Service-Licensee			
Ba	Depa Impo any i		108 William St			Tione
68760,	Physician and // Medical Examiner and physician and sthe pritian transit	dical Examiner	26a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as consolidations, the standard of the standard of the shock, or heart failure. List only one cause on each line.  Immediate Cause (Prinal disease or conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	a Dis	east	Onset and Death  Cewy
P.O. Box (	Physicien: The law requires that the death certificat this certificate has been signed by the attending phy ral director, page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of de Month	livery Day Year
	uires that signed b lid be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		d tobacco use contribute t ☐ Yes 2 ☐ No 3 ☐ P	
Division of Vital Records,	sicien: The law require certificate has been sig irector, page 2 should b	Completed			itopsy prior to prormed? death?	utopsy findings available completion of cause of
Zi.	sicien s certifi director	To Be	examiner?	of Death (Check on rsing Home 5 🗆 Re	ly one) esidence 6 □Other (Spe	ecify)
ion of	Attending Physic death.  ector: After this by the funeral di		20 7 1 1 20 7 1	28d. Describ	be how injury occurred	
Divis	To the Hospitel or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		n (Street and Number or F Town, State)	lural Route Number,
	ne Hospitel or 24 hours afte ne Funeral Dir sletely filled in l	Medical		d place, and due to t th occurred at the tim	he cause(s) and manner a ne, date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complei	X	29b. Signature and title of certifier  29c. License number	69	29d. Date signed (Mon	ith, Day, Year)
	BA2		30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)  N. Wales Boroslutin	Hechever 1	Fauch Fr	ladoc 1924
	Sta Regist		31. Date filed (Month, Day, Year)  DFC. 0.1 2006	0 /		,

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 Amend item# Registrar 14 per FH/wichd/12-1-06/dls Certificate of Death 3. Time of Death a 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** Mayhood November 29, 2006 8:05 Elizabeth /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner John B. Parsons Home Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 M 2 F 111-14-0322 unknown Director 6/12/1924 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County in then "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director Salisbury Maryland Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21801 300 Lemmon Hill Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White etc. filed within 72 hours after 1 ☐ Yes 2 K No Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Missionary Religion unknown unknown Department of Health and Manner Importent: If item 27 is many injury or other other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unknown unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PO Box 650, Fruitland, MD 21826 Rev. Gloria Ortiz/friend Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition SpringhillionMemory 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/4/06 Hebron, MD \* 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Funeral Service Ligensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OF LIVER Physician CIRRITOSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 \( \text{Yes} \) 2 \( \text{No} \) No 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No autopsy performed? 2 No Division of Vital To the Hospitel or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Juhn 13 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) Parson 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending Homes 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 T Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 15 2006 00 573 59 Normber 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415 S. DIVISION ST. SALISBURY DR-USHA NATESAN. M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 3

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

2006

			For State Registrar	State	of Marylan		artment of H			_	giene Reg. No.	006	39862
	Physici /Medic	al	1. Decedent's Name (First, Middle Elroy (	Corneliu	ıs Mat	thews				2. Date of De. Month 11	27	2006	3. Time of Death
	Examin Funeral	er	4a. Fecility Name (If not institution  Coastal Hosp  5. Social Security Number	ice At T			4b. City, Town, o	bury	24 Hrs	8. Date of Bird	Wico	omico  9. Birth	
į.	Director		231-70-8473 Usual Residence of Decedent  10a. State 10b. County	1 <b>½</b> M 2□ F	56	Yrs.	Months Days	Hours	Min.	(Month, Da 12-28-	-1949	Vii	cginia
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tem 27 is marked other than "naturel", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at ODGe.	Funeral Director	MD Wicom		Toc. Cit		isbury 10f. Zip Code	0.4			10g. Citizen	of What Cou	10d. Inside City Limits  1 Yes 2 □ No  untry?
o S	rs after death v ", or items 23s	by Funeral	712 Hemlock  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dec	2 No ive		218 Was Decedent of H If Yes, specify Cub 1□Yes 2▼No	lispanic Ori an, Mexicar		cify Yes or No Rican, etc.)	E	Race - Amer Black, White	, etc.
21213-0030	2 should be flied within 72 hours after of and Mental Hygiene. Is marked other then "naturel," or item aumatic event, the Medical Examinat	Completed t	15. Deceden (Specify only highes Elementary/Secondary (0-12)	t's Education of grade completed,		16a. Decei (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during mos d)		ng		f Business/li	
yland 2	tould be filed I Mental Hygin harked other hatic event, II	To Be Co	17. Father's Name (First, Middle,	n Matth	ews			18. Mothe	er's Name	(First, Middle,	5		
ore, Mai	jes 1 and 2 st of Health and it item 27 is n or other traun		19a. Informant's Name/Relations  Josephine Ma  20a. Method of Disposition  1	tthews	20b. F	712	ng Address (Street  Hemlocl sition (Name of matory or other pla	k St.	Sa		y, MI 20c. Locatio	0. 21 on - City or T	804 Town, State
Банттог	permit. Pag Department Important: eny injury once.		4 Donation 5 Other (S	pecify)	De	22	ance Ce	ss of Facilit	by Be	nnie S	Smith	F.H.	, MD.
,	Physician		23a. Part 1. Buter the disease or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on	each line.				cardiac o	r respiratory ai	rest,	Jry,	Approximate Interval Between Onset and Death
k	law requires that the death certificate be executed  BDD  BDD  BDD  BDD  BDD  BDD  BDD  B	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to	(or as a conseq (or as a conseq (or as a conseq	uence of):	Failure Asing						5year
O. BOX O	the death certific y the attending p ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live	itcome of pregna birth 2 ☐ Feta nant at time of d	Ideath 3	Ectopic pregnanc	у			1	Date of deliv Month	rery Day Year
ecords, P.	quires that an signed by uld be deta	۵	Part II. Other significant condition	ons contributing to c	leath but not res	ulting in the u	nderlying cause giv	ven in Part I.			obacco use c		the cause of death?
ř	The la ate has page 2	Completed								24a. Was autop perfo 1 \( \text{Yes} \)	an 24 osy rmed? 2 No	b. Were autoprior to codeath?	opsy findings available ompletion of cause of 2 No
II OI OI	To the Hospital or Attending Physician: within 24 hours after death To the Funarel Director: After this certifica completely filled in by the funeral director,	ion: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pendin	Hospital: 1 (4)	Inpatient 2 of Injury	ER/Outpatier 28b. Time of Injury	28c. Inju	ner: 4 □ Nu ny at rk?	ırsing Hor	(Check only one 5 Residence 128d. Describe to 128d.	dence 6 🗆 🤇		ify)
DIVISION	ital or Attend rs after death el Director: led in by the f	Certification:	2 Accident investig 3 Suicide 6 Could a 4 Homicide determ	not be ined 28e. Plac build	ling, etc. (Specif	y) 	eet, factory, office	Yes 2	2	City or Tow	vn, State)		al Route Number,
	the Hosp thin 24 hou the Funal mpletely fil	Medical	29a. Certifier (Check only one)  2		e best of my kno basis of examina nner stated.	wiedge, deati tion and/or in	occurred at the til vestigation, in my o	pinion, dea	d place, a	ed at the time,	cause(s) and date and place 29d. Date sig	ce, and due t	to the cause(s)
1			30. Name and address of person	Da.	USHA N		D		59		_		30 15 2006
1	°Sta		1415 S. DIVI 31. Date filed (Month, Day, Year)	SION ST	, SAUIS/ Registrar's Signa	34 Ry	MJ 218	04					
	Registr	aı	DEC 0	1 2006	Calledon.	K B	madi 1						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** December 1, 6:46 P.M Marie Rosina Moore /Medical 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert County Nursing Center Prince Frederick Calvert 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1□ M 2**X**) F Months Hours Director 212-05-2530 Jun. 16, 1915 Maryland Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location permit. Pages 1 and 2 s ould be filed within 72 hours after death with the Marylan Department of Health an Mental Hygiene. Important: If Item 27 is narked other than "natural", or items 23a or 28a-f show any Injury or other traunal cevent, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21858 Magnolia Drive 20619 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo δ Specify: 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Robert F. Kahlein ဨ Frances Kostusch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph K. Moore, Jr./Son 21858 Magnolia Drive, California, MD 20619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Pk 5, 2006 Sykesville, Maryland 21. Signature of uneral rivice Lie See Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician SEPSIS SYNDROME disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy 1☐ Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D40370

State Registrar

110 Hospital Road, Prince Frederick, Maryland 20678 31. Date filed (Month, Day, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter Wisniewski,

Physician /Medical Examiner Examiner   Physician /Medical Examiner   Physician	4a. Facility Name (If not institution, s St. Mary's Hosp	Chase Mil		L	ily, Town, o	r Location of D	2. Date of Month DECEM	BER 2	2006	3. Time of Death 7:15
Funeral Director	St. Mary's Hosp 5. Social Security Number 132-30-9734  Usual Residence of Decedent 10a. State 10b. County  Maryland St. Ma	oital .Sex 7.7	Age (In yrs. last birtho	L	ily, Town, or	Location of D				
Director	132-30-9734  Usual Residence of Decedent  10a. State 10b. County  Maryland St. Ma			4 1 16 1 100	eonar	dtown			ounty of Deat t. Mar	
1 1-	Maryland St. Ma			Mont	hs Days	If Under 24 H Hours N	frs. 8. Date of (Month, Februa	Birth Day, Year) ry 11,19	9. Birt Co New	nplace (State or Fore untry) York
I, or tems 23a or 28c card per puest be und by Funeral Direc		rv's	10c. City, Town o	or Location	od					10d. Inside City Lin
I, or Items 23a					Zip Code			10g. Citize	on of What Co	untry?
r, or Item	24881 Sotterly F				20636				SA	
6 W	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Force: 1	s? ≬No	If Yes, s	scedent of Hispecify Cuba	ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes or ento Rican, etc.)		Black, White pecify:	
ygiene. ner than "natura t, the Medical E	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		r 5+)	give kind of fe. DO NO	T use retired	during most of (	working		of Business/	ndustry
I Hygie other t	12 17. Father's Name (First, Middle, La	st)	Sc	poot	Bus Di		Name (First, Midd		Compan	<u>y</u>
Mental H arked otl atic ever	Bruce H. CHase	,					S. Shum		amamo)	
• mar	19a. Informant's Name/Relationship	(Type, Print)	19b. N	lailing Addr	ess (Street a		Rural Route Nur		Town, State, Z	ip Code)
of Health and Ment	Raynold W. Miller,	Jr. / Son	Contract of the Contract of th			-	lywood, Ma	-		
Department of H Important: If Ite any Injury or ott gnce.	20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spe	☐Removal from Stat	e 20b. Place of D cemetery, Metropoli	tan Cr	ematory	4,	cember 2006	Alexan	ition - City or i idria, Vi	rginia
Departi Import any Inj pnce.	21. Signature of Funeral Service Lig	n Hardin	er				httingley town, Mar			1 Home, P.
ysician	23a. Part1. Enter the disease, or oc shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	- PERF	od the death. Do not line ORATED is a consequence of)	GI			I LC	-		Approximate Interval Between Onset and Deat DAYS
ransit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	A STATI ( s a consequence of)		4571	210	CARC	INOM	A	MONTH
ding Se as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		e of pregnancy 2 □ Fetal death at time of death	3 Ectopid	pregnancy (specify)			230	d. Date of delin	very Day Year
	Part II. Other significant conditions	contributing to death	but not resulting in th	e underlyin	g cause give	on in Part I.		tobacco use		the cause of death
cate has been si page 2 should I								topsy rformed?	24b. Were aut prior to codeath?	opsy findings avail ompletion of cause 2 No
certifi rector	25. Was case referred to medical examiner?	Hospital:			Otho		eath (Check only	y one)		
After this certificate has funeral director, page 2	1 Yes 28 No  27. Manner of Death  1 Natural 5 Pending  1 Accident investigat	28a. Date of In (Month, D	jury 28b. Tim	e of	28c. Injury Work	4   Nursing	Home 5 ☐ Re 28d. Describ	e how injury o		fy)
within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Medical Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Ir	njury - At home, farm etc. (Specify)			2 2 3 10	28f. Location City or T	(Street and Nown, State)	lumber or Rui	al Route Number,
thin 24 hours the Funera mpletely fille	29a. Certifier 1 Certifying (Check only one) 2 Madical Ex	Physician: To the bes aminer: On the basis and manner s	of examination and/o	eath occurr r investigati	ed at the tim ion, in my op	e, date and pla inion, death oc	ce, and due to th curred at the time	e cause(s) an e, date and pl	d manner as	stated. to the cause(s)
To the comp	29b. Signature and Ittle of certifier	ex .	MD	1	29c. License	number 1752	}		igned (Month,	Day, Year) 2,200
	30. Name and address of person wh JOHN HA 31. Date filed (Month, Day, Year)	RVC-Y S-	T. MARY	5 HC	XP17	AL, L	EONAR	D70W	, N	1)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 39865 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Edith Wilder Meaux 8:27 P 11/25/2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 16113 Presidio Way Bowie If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months Hours Min. 1 □ M 2 F 474-22-1818 103 Director Oklahoma 11/29/1902 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ir than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at MD 1X Yes 2 □ No PG Director Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16113 Presidio Way USA death Funeral 20716 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
AMERICAN within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ 3 XWidowed 4 ☐ Divorced INDIAN Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other traumatic event Private 12th Landlord 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be AMANDA MANLEY William Madden 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 16113 Presidio Way, Bowie MD 20716
Date Of Disposition (Name of Date 20c, Location - City or Tow Mary Busby/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Lakewood Cemetery 12/2/2006 4 ☐ Donation 5 ☐ Other (Specify) Minneapolis, MN 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lymphatic Malignancy **Physician** /Medical Due to (or as a consequence of) Examiner DVT Left Leg Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit certificate be executed Due to (or as a consequence of) attending physician Box 68760 Physician/Medical as the IF FEMALE: nse : 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal de 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No ò Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 sate has been signed by the page 2 should be detached 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2**x** No 1 Yes 2€ No Attending Physician: After this certification 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 70 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Injury all or Ah.

ours after dean

of Director: Ah.

in by the for-1 X Natural 5 Pendina 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 \*\*Certifying Physician\*\* To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examina 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58289 11-27-06 (Mary moe) Henns 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffery T. Hoeck M.D. 4175 North Hanson Court Suite 203A Bowie, Maryland 20716 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 28 2006 Registrar

			1 = State Registrar				Cei	rtificat	e of L	Death	1	F	Reg. No.		
	Physici	an	1. Decedent's Name (First, Mid	die, Last)						1.		2. Date of Dea Month		Year	3. Time of Death
	/Medic		MARY			RAE						NOVEMB	ER 19	2006	5:33 A M
*	Examir	ner	4a. Facility Name (If not instituti MANOR CARE	NURSING	HOME				LAI				PR		EORGE'S
ė	Funeral Director		5. Social Security Number  242–09–0094  Usuaf Residence of Decedent	6. Sex 1 □ M 2 🛣	-	ge (In yrs. ia: <b>91</b>	St birthday) Yrs.	If Under Months		If Under Hours		8. Date of Birth (Month Day MAY 16	Ĭ <b>9</b> 15	9. Birt	hplace (State or Foreign H CAROLINA
	Maryland -f show	tor	10a. State 10b. Coun	E GEORGE	¹ S		Town or Lo		STON	***					10d. fnside City Limits
	with the 3a or 28a	I Director	10e. Street and Number 4100 PINEHURS	T DRIVE				10f. Zip	Code )744				_	on of What Co	ountry?
020	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Ma 3 M Widowed 4 Divorce	Armed 1 🗆 Y	Decedent i Forces es 2 X Give or Dates:	No		Was Deced f Yes, spec 1 ☐ Yes		spanic Or n, Mexica Specify		cify Yes or No- Rican, etc.)		I. Race - Ame Black, White Specify:	
0-0171	vithin 72 ho ne. han "natur e Medical I	Completed	(Specify only high Elementary/Secondary (0-12)	ent's Education est grade complet College	<i>ed)</i> ge (1-4or	5+)	life. L	dent's Usua kind of wo DO NOT us USE W	rk done d se retired	luring mos	st of workin	g		of Business/	Industry
ם וב	d be filed vintal Hygis	o Be Co	8th 17. Father's Name (First, Middle LLOYD HARRIS	e, Last)				DOE W	LPE	18. Moth		(First, Middle,	Maiden Si		
Mary	and 2 should is saith and Men n 27 is marke	ř	19a. Informant's Name/Relation PATRICIA A. J	, , , , ,	HTE	3				and Numb	er or Rural	Route Number	r, City or 1		
	Pages 1 and 2 nent of Health Int: If Item 27 Iry or other tra		20a. Method of Disposition 1	n 3 ∏Removal fr		20b. Pla	ce of Dispo netery, cren NCOLN	natory`or o	ther place	9) 1	1/27/	2006 S		ation - City or	
ספור	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service				Cross	Name an			J .	B. JEN			AL HOME 20785
0,00,0	Physician number of medical physician and physician and se as the prinal-transit	/Medical Examiner	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. H Due  b. R Due  Due  C. D	YPER to (or as ENAL to (or as	TENSIO s a conseque INSUF s a conseque	ON ence of): FICEN ence of):		e of dying	g, such as	cardiac or	respiratory am	est,		Approximate Interval Between Onset and Death
O. DOY O		Physician/Me	if FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Li 4 □ Pi	ve birth	e of pregnance 2  Fetal d at time of dea	leath 3	Ectopic pr Other (sp					230	d. Date of deli Month	very Day Year
Olds, F.	w requires that the death been signed by the atten should be detached for u	by	Part If. Other significant condi	tions contributing t	o death I	but not result	ing in the ur	nderlying c	ause give	n in Part f	l.		100		the cause of death?
	: The law recate has be page 2 sho	Completed						-				24a. Was a autops perform	n 2 by ned? 24 No	24b. Were au prior to d death? 1 \( \text{Yes}	topsy findings available completion of cause of
VISION OF VIC	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	ertification; To Be	3 Suicide 6 Coule	Hospital: 1  28a. D  (A  tigation d not be 28e. P	Inpati	urv 2	R/Outpatien 8b. Time of Injury	M 2	8c. Injury Work 1 🗆 Y	r: 4 <b>⊠</b> Ni	ursing Hom 20	(Check only online 5 Reside  Bd. Describe ho  Bf. Location (St. City or Town	ow injury o	occurred	ral Route Number,
2	Hospital o	edical Cer	(Check only 2 Medica	ing Physicien: To	the best	t of my knowl	edge, death	occurred restigation,	at the tim	e, date an	nd place, ar	nd due to the c	ause(s) ar	nd manner as	stated. to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certif	and n	unner st	ince	ea	290	License	number		2	9d. Date s	signed (Month	
)_	6		30. Name and address of perso ALAIN CHAMP					Print)			UPPER	MARLBO			
	Sta Registr		31. Date filed (Month, Day, Yea			rar's Signatur									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 39857 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22 2006 **Physician** NOVEMBER MARLENE MAYO 23:59 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner LAUREL REGIONAL HOSPITAL PRINCE GEORGE'S LAUREL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | FEB 16 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F MARYLAND 216-40-8894 69 Yrs Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Itama 23a or 28a-f show Examiner must be notified at Director MDPRINCE GEORGE'S LAUREL 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8904 ASCOT LANE # 23 20708 U.S.A. Pages 1 and 2 should be filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3₺ Widowed 4 Divorced "natural" BLACK al Hygiene. I other than "natura ivent, the Medical E ieted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Compi Elementary/Secondary (0-12) College (1-4or 5+) CIRCULATION ASSISTANT GOVERNMENT 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ith and Mental H 27 is marked of traumatic ever REYNOLDS SADIE RODNEY RICE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health ZITA DICKERSON/DAUGHTER 6980 KNIGHTHOOD LANE COLUMBIA, MARYLAND 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State partment of hoortant: If Ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) HARMONY CEMETERY 12/4/2006 LANDOVER, MARYLAND 21. Signature of Fundral Service Licenses. permit.
Departn
Imports
any Inju 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION **Physician** /Medical Due to (or as a consequence of) Examiner HYPERTENSION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and is the burial-transit DIABETES MELLITUS resulting in death) Last Due to (or as a consequence of): .O. Box 68760, Physician/Medical attending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Δ, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, OBESITY 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 2 🔀 No 1 Tes 21 No 1 🗌 Yes of Vital Attending Physicien: director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this the funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division 1 🖾 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after de To the Funaral Directo completely filled in by th 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis or examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and fitte of contifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 ed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 2D.

32. Registrar's Signat

			1 - For State Registrar		State	of Maryl	and / Depa	artment rtificate			and M	ental F		2 U I	)6	39868
1	Dhysisi		Decedent's Name (First, )	Aiddle, Last,	)				0, 2	- Catri		2. Date of Month		No. Day	Year	3. Time of Death
	Physici /Medio	al	EVELYN		ALES								MBER	18 2	006	9:07 A M
	Examir	er	4a. Facility Name (If not insti 8013 CLAR)						Town, or VERN	Location o	f Death			4c. County  ANNE		
	Funeral		5. Social Security Number	6. Se:	K	,	yrs. last birthday)	If Under	1 Year	If Under 2		8. Date of			9. Birth	place (State or Foreign
	Director		046-62-7554		M 2023.F	45	Yrs.	MONINS	Days	Hours	Min.	APRIL	. 13	1961	PUE	RTO RICO
	yland wow		Usual Residence of Decede 10a. State 10b. Co			10c.	. City, Town or Lo	ocation								10d. Inside City Limits
	e Mar	ctor	MD ANNI	ARUN	DEL		SEVERN								i	1 XYes 2 No
	or 28	Director	10e. Street and Number					10f. Zip	Code				10g. (	Citizen of V	What Cou	intry?
	eath v	Funerai	8013 CLARK S			) cedent Ever i	in II S   12	Was Deced	1144		in? (Sna.	adu Vas as		.S.A.		ican Indian,
920	be filed within 72 hours after death with the Maryland ital Hygiene. Hygiene do dother than "naturel", or Iteme 23e or 28e-f ehow event, the Mudical Examiliar must be notified at	þ	1 ☑ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo	Married	Armed F	orces? 2 <b>½</b> No ive		If Yes, spec 1 ■ Yes 2	rfy Cubar	Specify:	Puerto F	Rican, etc.)		Specify	k, White	spanic
5-0036	72 ho	eted	15. Dec (Specify only h	edent's Edu	cation	)	16a. Dece	dent's Usua kind of wor	l Occupa	tion				Kind of Bu		
2121	within ene. than	Completed	Elementary/Secondary (0-		College	(1-4or 5+)	life.	DO NOT us	e retired)	anny most	Or WORKIN	9		DD TXI A	mv	
2	e filed within al Hygiene. I other than '	e Co	17. Father's Name (First, Mic	Idle, Last)	3 3	/15	FA	RA LE		18. Mother	's Name	(First, Midd		PRIVA en Sumam		
ılan	should be nd Mental marked o	To Be	LUIS MORALE	S							NES	ALAM			,	
Maryland	and and ls m		19a. Informant's Name/Rela	tionship (Ty	pe, Print)		19b. Mailir	ng Address	(Street a	nd Number	r or Rural	Route Nun	nber, City	or Town,	State, Zi	p Code)
	1 an Heal em 2 ther		DEBORAH GRI 20a. Method of Disposition	ENE/P	ARTNEF		8013 b. Place of Dispo	CLAR	K ST	ATION		SEVER	-			1144 own, State
altimore,	Pages nent of int: If it iry or o		1 Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth		emoval from	State	cemetery, crer akeview	matory or ot	her place	· I		 )/200 <i>6</i>				t, CT
alt.	permit. Pages Depertment of Importent: If it eny injury or one		21. Signature of Euperal 3er		90	11		2. Name and								
<u> </u>	8 3 E 5 8			$\leq$				474 La						MD 20	0785	
¥.			23a. Part1. Enter the diseas shock, or heart failure.	e, or compli List only or	cations that ne cause on	caused the d each line.										Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		00	u C	Gnc	e-		7-61	1621	417	<u>_</u>		Onset and Death
	Examiner					(or as a con:	sequence of):	20 nc	ceae	ز م						2 years
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	J '		(ur as a cons	sequence of).		•							
	ecuted and I-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	۰	t. Due to	(01.35.3.000	sequence of):									
8760,	ficate be executed physicien and s the burial-transit		,		. ==	(or as a cons	sequence on).									
U	tificate ig phy as the	ledicai														
ROX	death certifi e attending d for use as	an/N	IF FEMALE: 23b. Was decedent pregnan in the past 12 months?	2		tcome of pre		]Ectopic pre	egnancy					23d. Date		,
	0 60	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∏Preg 9☐ Unkn	nant at time o		Other (spe						Mor	าเก	Day Year
J.	law requires that the as been signed by the 2 should be detache	by Ph	Part II. Other significant cor	ditions con	tributing to d	leath but not	resulting in the ur	nderlying ca	use giver	in Part I.		23e. Did	tobacco	use contr	ibute to t	he cause of death?
ecords,	w require been sig should bo							_				10	] Yes	No	3 🗌 Prot	pably 4 ∐Unknown
ပ္ပဲ မ	lawra nas be	Completed										24a. We	as an topsy	24b. V	Vere auto	ppsy findings available mpletion of cause of
	icien: The lav certificete has rector, page 2											1 Yes	folloped?	d	eath?	
VItal	Physicien: r this certifice ral director, p	o Be	25. Was case referred to me examiner?	_	ospital:	Inpatient 2	2 ☐ ER/Outpatien	at 3 DOA	Othor			Check only		. 530		
	ding Phy h. After this funeral c	$\vdash \Vdash \Vdash$	27 Manner of Death		28a, Date		28b. Time of		c. Injury a	at Non	sing Hom 28	e o He 3d. Describe		6 Othe		у)
S S	Attending ir death. ector: Alter by the fune	catic		estigation uld not be			,,.,,	М		es 2 □ N	0					
_	- 2.5 -	ertification:	3 Suicide 6 Co	termined	28e. Place build	e of Injury - A ing, etc. (Spe	at home, farm, stre ecity)	eet, factory,	office		28	Bt. Location City or T	(Street a	ind Numbe te)	or Or Rura	al Route Number,
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	edical C	29a. Certifier (Check only one)	ifying Physical Examir	<pre>ser: On the b</pre>	e best of my loasis of exam	knowledge, death anation and/or inv	occurred a vestigation, i	t the time in my opii	, date and nion, death	place, an	nd due to th	e cause( e, date ar	s) and mar	ner as s	tated. o the cause(s)
	To thin To thin compl.	≥	29b. Signature and title of ce	rtifier	-			29c.	License	number	136	`	29d. D	ate signed	(Month,	Day, Year)
			1 lendy	2	150	lool	y our	2	92	77	3 5	5	No	Je my	ser	22,2006
	(12)		30. Name and address of per Mayer G	son who co	mpleted cau	se of death (I	Item 23a) (Type, i	Print)	. 6	5	01	G/a	R		11	1 2 = 1
	Sta		31. Date filed (Month, Day, Y			Registrar's Sig		194	ر سي	′ ′	er'n	5/60	, Du	rua	04/2	7 -1061
	Registra		NOV 2.9		Ke al	1	Speed	U								

Amend #12 per FH 11-29-06 AACo. G

-2	9-06	ΑĀ		te of Maryland / Dep	delible Ink. Ensure A artment of Health and I rtificate of Death	Mental Hygier	ne	00
<i>)</i>	Physic /Medi Examii	cal	1. Decedent's Name (First, Middle, Last)  Mathhew Joh  4a. Facility Name (If not institution, give street a  THE JOHNS HOPKIN	nd number)	M cDonald  4b. City, Town, or Location of Death  BALTIMORE	November	Day Year	eath M
	Funeral Director		5. Social Security Number 220−40−4153	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yes) 7/14/1943		
	th the Maryla or 28a-f ehov	Director	Maryland   10b. County   Maryland   Anne Arunde   10e. Street and Number   10e. Street and Numbe	1 10c. City, Town or La		10g. (	10d. Inside City t 1 ☐ Yes 2  Citizen of What Country?	
036	mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland of Arath and Mental Hygiene. Cortant: if Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at al.	by Funeral	1 ☐ Never Married 2 ☒ Married 1 ☒ HY	Yes 2 Till No	21012 Was Decedent of Hispanic Origin? (Stiff Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify: White	
Maryland 21215-0036	filed within 72 h Hygiene. other than "natu	Completed	5+	leted) 16a. Dece (Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired) Chologist	ing	Kind of Business/Industry Psychology	
aryiand	should be filed withir ind Mental Hygiene.  marked other than umatic event, the Mi	To Be	17. Father's Name (First, Middle, Last)  Charles Thomas I  19a. Informant's Name/Relationship (Type, Prir			e (First, Middle, Maid Brungs ral Route Number, City		
	ages 1 and 2 nt of Health a t: if item 27 is y or other tra		P. Gayle O'Callaghan/ 20a. Method of Disposition  1 Burial 2 Cremation 3 Removal	Wife 699 grown State 20b. Place of Disponsion State	White Swan Drive sition (Name of matory or other place)	, Arnold, Date 20c.	Maryland 21012 Location - City or Town, State	
Baltimore,	permit. Pages 1 Deportment of H Important: if its any injury or ot once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service/Licensee	2	2. Name and Address of Facility Geo 973 Solomons Isla	orge P. Ka nd Rd. Edge		
1	Physician /Medical		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	e on each line.	or the mode of dying, such as cardiac hageal cancer	or respiratory arrest,	Approximate Interval Betwee Onset and Dea 5 Year	
,007	te be executed by ysicien and burial-transit control of the burial	icai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	we to (or as a consequence of):	,		3 days	S
T.O. DOX 001	The law requires that the death certificate te has been signed by the attending physage 2 should be detached for use as the	by Physician/Medic	in the past 12 months?		Ectopic pregnancy		23d. Date of delivery Month Day Year	ır
	w requires that been signed b should be deta		Part II. Dther significant conditions contributing	g to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of deat 2 No 3 Probably 4 Dunke	
DIVISION OF VITAL RECORDS,		Be Completed	25. Was case referred to medical		26 Place of Deat	24a. Was an autopsy performed? 1 Yes 2 N	24b. Were autopsy findings ava. prior to completion of cause death? 1 □ Yes 2□ No	ulable se of
5	Physical this ce	2	examiner? 1 Yes 2 No Hospital:	1 Inpatient 2 ☐ ER/Outpatien	t 3 DOA Other: 4 Nursing Ho	me 5 Residence		
2	Attending Physician: It death. ector: After this certifice by the funeral director, to	ation	27. Manner of Death  1 Naturat 5 Pending 2 Accident Investigation	Date of Injury 28b. Time of (Month, Day Year) Injury	28c. Injury at Work?  M 1 Tyes 2 No	28d. Describe how inj	ury occurred	
22	To the Hospital or Attan within 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, strobuilding, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)	,
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	Medicai	Z medical Examiner: On	o the best of my knowledge, death the basis of examination and/or inv manner stated.	occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause( ed at the time, date ar	s) and manner as stated.  nd place, and due to the cause(s)	
•	To the withir To the comp	Me	29b. Signature and title-procertifier  April 1999  20 Name and artifact and account account and account account and account account and account account and account account and account account account and account account and account account account and account account account account and account account account account account and account accoun		29c. License number RES-000		late signed (Month, Day, Year)  /CMBCY Z6, 200	06
	Sta Registr	_		NS HOPKINS HOSPIT 32. A. strar's Signature	AL 600 NORTH WOLFE	STREET BAL	TIMORE, MD 21287	†
DH	MH 17 Rev 1/20			Bloom B. A.				

			1 - For State Registrar	State of I	Marylar		artmen <i>rtificate</i>			and M	_	gien	2000	39870
			Decedent's Name (First, Middle	Last)							2. Date of De	ath		3. Time of Death
Į.	Physici /Medio		Mar	y Janice Mo	cKenzi	Le					Novemb	er 2	25,2006	12:32 A M
	Examin		4a. Facility Name (If not institution	give street and number	er)		4b. City,	Town, or	Location o	of Death		40	c. County of Dea	ath
			Anne Arundel M 5. Social Security Number			last birthday)	Anna If Under		S If Under:	24 Hre	o Data of Ric	46	Anne An	
	Funeral Director		037-14-8855	1□M 2□F	80	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Nov . 28	y, Year	25 Rh	othplace (State or Foreign ountry)  ode Island
	pu ,		Usual Residence of Decedent								1101120	, 1 / 2	25   16110	
	shov	J.	15	T	10c. Cr	ty, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	rect	10e. Street and Number	arundel		АП	napol					10a C	itizen of What C	11
	h with	I DI	5109 River Cres	cent Drive			101. 2.10	214	01			-	ited Sta	,
	ems sermin	Funeral Director	11. Marital Status	12. Was Decede Armed Force	nt Ever in U	.S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	-	14. Race - Am	
36	within 72 hours aftar death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examinat must be notified at	by Fu	1 ☐ Never Married 2 ☐XMarri 3 ☐ Widowed 4 ☐ Divorced	ed 1 [Yes 2] If Yes, Give	ĮΝο		1 ☐ Yes 2		Specify:	,			Black, Whi	White
8	thour	ed b	15. Decedent	Year or Date	s: 	16a, Dece	dent's Usua	I Occupa	tion			16b k	Kind of Business	
215	hin 72	Completed	(Specify only highes Elementary/Secondary (0-12)		or 5+1	(Give	kind of wor DO NOT us	k done d	urina most	t of worki	ing	100.1	tind of oddiness	viridustry
2	ad wil	Соп		4		Subs	titut	e Te	acher	<u> </u>			Educati	on
Maryland 21215-0036	ba fill ntal H ed oth even	Be	17. Father's Name (First, Middle, L	am Francis	Llood.						(First, Middle,		n Sumame)	
<u>Z</u>	should nd Mei mark matic	은	19a. Informant's Name/Relationsh		wood	19h Mailir	an Address	(Street a			lexand		or Town, State,	Zin Codel
Z	nd 2 salth ar		Leon McKenzie										olis, MI	
ore,	as fa of Hea item rothe		20a. Method of Disposition 1 Derial 2 Cremation		20b. F	Place of Dispo cemetery, crer				-	ate		ocation - City or	
Ĕ	Page ment ant: It ury o		`4 □ Donation 5 □ Other (Sp	acify)	ro I	timore				1/28	3/06	Ba1	timore,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene and Instruction of the 23a or 28a-1 show any injury or other traumatic event, the Medical Examination at the notified at once.		21. Signatury of Funeral Service L	Densee 1	_						nn M. Ta	ay1c	r Funer	al Home,Inc.
	TO = 6 0	-	23a Part   Enter the disease or	J. Juli	ed the deat								napolis	, MD 21401
	Db		23a. Part1 Enter the disease, or shock or heart failure. List of Immediate Cause (Final		VAL	FA!	ロレング	L	, sucii as (	cardiac o	i respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	as a conseq			- 10						
	Examiner		Sequentially list conditions	b. UT	ENI	いっ	51	tnc	omA	-				
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a conseq	uence of):								
	xecuti and al-tran	хап	that initiated events resulting in death) Last	c	as a conseq	uence of):								
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical E	ļ			,								
9	rtificat ng phy as th	Medi	IE EENALE											
Вох	leath certific attending p	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1 ☐ Live birth	2 Feta	Ideath 3	Ectopic pre	griancy					23d. Date of de	livery Day Year
P.O.	that the de led by the a detached f	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant 9☐ Unknown		eath 5□	Other (spe	cify)					WOITH	Day 16ai
	that the by detail	y Ph	Part II. Other significant condition	s contributing to death	but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	bacco	use contribute to	the cause of death?
Division of Vital Records,	quires in sign										1 □ Y	es 🙎	ZNo 3□Pr	obably 4 Unknown
000	e law requir has been s je 2 should	Completed									24a. Was		24b. Were at	itopsy findings available
ř	The I	Com									autop perfor 1 \( \text{Yes}	sy med? 2 No	death?	completion of cause of
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:							(Check only or			2012
ō	Phys r this ral dir	 7	1 ☐ Yes 2 ☐ No  27. Manner of Death	Hospital:		ER/Outpatien 28b. Time of		Other	4 🗀 Nur		ne 5 Resid		6 Other (Spe	cify)
o	nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, L	Day Year)	Injury	М	Work	? es 2 □ N			011 111/01	y coodings	
N	r Atte er dez rectol by th	Certification;	3 Suicide 6 Could not determine	and 286. Place of	njury - At ho etc. (Specif	ome, farm, stre	eet, factory,	office		2	8f. Location (S City or Tow	itreet an	d Number or Ru	ıral Route Number,
ā	rital o			1						Ť				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director;	edical	29a. Certifying (Check only one)  2 Medical E	Physician: To the best	of examina	wledge, death tion and/or inv	occurred a restigation.	t the time in my opi	a, date and nion, death	d place, a h occurre	nd due to the o	ause(s) date and	and manner as place, and due	stated. to the cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier	and manner	512160.		29c.	License	number		2	29d. Dat	te signed (Monti	h, Day, Year)
	->-0		Vilous /h	1/2			1	) 4	76	12			11/2	7/06
	. =		30. Name and address of person w		death (Item	1 23а) (Туре, І			,					
	15		Dr. Paul J. M. 31. Date filed (Month, Day, Year)				venue	, Su	ite 2	201	Annapol	is,	MD 21	401
	Sta Registra		NOV 2 8	2006 Jane	strar's Signa	K Sp	and the							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year a M Dorothy May Murray November 25, 2006 6:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kensington Nursing & Rehab. Center Kensinatan Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month Day, Year) Oct. 22, 1916 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 🖼 F Months 90 184-22-7733 Director Pennsylvania Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location in then "natural", or Items 23a or 28e-f show the Medical Experiment periodified at 10d. Inside City Limits Director 1 ☐ Yes 🏖 ☐ No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3601 Lawrence Avenue 20895 death USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Americen Indian, Black, White, etc. filed within 72 hours after ☐ Yes S 3√ No 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Speci**W**hite þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then eny injury or other treumatic avent Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lambert Deeter Elsie May Bowmen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elwood Russell Murray/ Husband 3601 Lawrence Avenue, Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) November 29 Parklawn Memorial Park 2006 Nockville, Maryland 21. Signature of Funeral Service Licen Francis and Address Fine Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physiclan/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Ninknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has be irector, page 2 s 24a. Was an autopsy performed? 1 Yes 2 🗹 No 1 Yes 2 (2No the Hospitel or Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death Check onl one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 ☑ Natural 2 ☐ Accident 5 Pending death. after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à determined 4 Homicide filled in within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10054566 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1220 A East JORPA ROLD, SWIN 2 30, TOWSEN, MD21286 Sunitha Bhogavila 32 Registrar's Signature 31. Date filed (Mon State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene

		Registrar	Certificate of Death	Reg. No. UU5 390/2
	S.	Decedent's Name (First, Middle, Last)		Date of Death     3. Time of Death
Physi		CATHERINE VERONICA MANDER	VILLE	DECEMBER 8,2006 8:40AM
/Med Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LXAII		9330 PENNS HILL ROAD	LA PLATA	CHARLES
Funer		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday) If Under 1 Year If Under 24 Hrs.	Date of Birth     9. Birthplace (State or Foreign
Funera Directo		4 The William	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreig Country)  NOV.19,1912 NEW YORK
		Usual Residence of Decedent		NOV. 19, 1912 NEW TORK
land ow		10a. State 10b. County 10c. City, Tow	n or Location	10d. Inside City Limits
Mary fsh jed	ŏ	MARYLAND CHARLES LA	PLATA	1 ☐ Yes XXNo
1he 288	Directo	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
death with the Maryland ms 23a or 28a-f show		9330 PENNS HILL ROAD	20646	U.S.A.
eath	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spe	
tten d	5	Armed Forces?  1 Never Married 2 Married 1 Yes 2 XNo	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) Black, White, etc.
FIZ IS-UU30 within 72 hours after death with the Marylan iene. rthan "neturel", or items 23a or 28a-f show the Madical Exemines must be suitified at	by	3XXVidowed 4 Divorced Year or Dates:	1 ☐ Yes 2X No Specify:	Specify: WHITE
Po Po		444	Decedent's Usual Occupation	16b. Kind of Business/Industry
n 72	Completed	(Specify only highest grade completed)	(Give kind of work done during most of workillife. DO NOT use retired)	ng
within 908.	E	Elementary/Secondary (0-12) College (1-4or 5+)		OWN HOME
filed Hygie Sither		12 17. Father's Name (First, Middle, Last)	HOMEMAKER  18 Mother's Name	OWN HOME
P de la pos	Be			
Taryla 2 should and Men is marke	ို			E SYCOSKI
Z st 2 st 1 s n 1 s n				al Route Number, City or Town, State, Zip Code)
e, n 1 and Health em 27				D.,LA PLATA,MD 20646
S to to o		20a. Method of Disposition 1	Disposition (Name of py, crematory or other place)	20c. Location - City or Town, State
Pages nent of ant: if it		4 Donation 5 Other (Specify) METROPO	LITIAN CREMATORY	12-9-06 ALEXANDRIA, VA
permit. Page Department important: if any injury or	ä	21. Signature of Feneral Service Licensee MOO	4 729. Name and Address of Facility	
n aasa	ä	Muhwel O. Kym		L SERVICE, P.A.
	9	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one conserve each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,  Approximate Interval Between
Physicia		Immediate Cause (Final disease or condition	Mc Depart 1- AS	Onset and Death
/Medica		resulting in death)  a. Due to (or as a consequence		
Examine	r	A DVANCEN	O. ATIDEROSCL	ENOSIS.
	ē	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence		
uted d	눝	cause. Enter Undertying Cause (Disease or injury that initiated events		
P, exec n an ial-tr	Examiner	resulting in death) Last  Due to (or as a consequence	of):	
sicia bur				
Certificate be executed ding physician and ise as the burial-transit	/Medical			
	M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
death death e etter	cla	in the past 12 months? 1 ☐ Yes 2 No  1 ☐ Yes 2 No	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month Day Year
Schart de C	Physicia	9 Unknown 9 Unknown		
ecords, F.O. BG law requires that the death as been signed by the etter 2 should be detached for u		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobecco use contribute to the cause of death?
VITAI HECOITAS, ician: The law requires t certificate has been signe rector, page 2 should be e	d by			1 Yes 2 No 3 Probably Unknown
w require been si	Completed			24a. Was an 24b. Were autopsy findings available
has has	E G			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
VICAL ME of vician: The lave certificete has rector, page 2				1 Yes 2 No 1 Yes 2 No
VIII iciar iciar certif ecto	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death	
Phys This	မ	1 Inpatient 2 EH/Ou		me 5 Residence 6 Other (Specify)
ing I	Ö	1 Natural 5 Pending (Month, Day Year)	njury Work?	28d. Describe how injury occurred
SIC feath for: /	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	
UIVISION I or Attending after death. Director: Afte	Certification:	4 Homicide determined 28e. Place of Injury - At home, fa	rm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
UNISION OF VITA  To the Hospitel or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director.				
Hosp thou rune	edical	29a. Certifier  (Check only  2 Medical Examiner: On the basis of examination and	death occurred at the time, date and place, a	and due to the cause(s) and manner as stated.  ed at the time, date and place, and due to the cause(s)
the the policy	ed	and manner stated.		*
5 til 5 0	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Pay, Year)
		1 Jul Du and	10000	1218/06
6		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	100 K My 206 13
Ψ		TRUNKING TOUR IN	3 MVJ, WALK	10111-1110 506 0
1.5 PM 5 11 11 11 11 11 11 11 11 11 11 11 11 1	tate	31. Date filed (Month, Day, Year)  DEC 1 4 2006  33 Registrar's Signature	hoest s	~
Regis	strar	DEC 1 4 2006 Stown &	STORE STORES	
DHMH 17 Rev	1/2001		*	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 006

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Virginia Ann Moore 1) E COMBEN 4:25 PM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Manor Healthcare Center Rising Sun Ceci1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛱 F Director JAN 2, 1920 235-28-5722 86 West Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iteme 23e or 28a-1 show any highry or other traumatic event, the Madical Examilier must be matified at once. 10d. Inside City Limits Directo 1 Yes 2 No Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Independence Drive 21921 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Yes 2 17 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry State Highway Elementary/Secondary (0-12) College (1-4or 5+) 12 Toll Collector Administration 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Isaiah Kidd Rosie Stover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa A. White/Daughter 102 Independence Drive, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cherry Hill
Methodist Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State December 1 \$\mathbb{M}\$ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11, 2006 Cherry Hill, Maryland 21. Signalure of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) Year Division of Vital Records, P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 TYes 2 No 3 ☐ Probably 4 ☐Unknown certificate has birector, page 2 si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Ē 2 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred Natural 5 Pending investigation death. Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide within 24 hours after de To the Funeral Directi completely filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 458419 DECEMBER, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roomer DonHama, 1831 TELEGRAPH ROAD, RISING SUN, MD 21911 Do 31. Date filed (Month, Day, Year) 🎢. Registrar's Signature State Registrar DEC 1 4 2006

		For	State of Maryla				Mental Hy	giene	
•	741	= State Registrar		Cert	ificate of L	Death		Reg. No. UU 6	398/4
Physic	ian	1. Decedent's Name (First, Middle, Las.	.00				2. Date of De Month	ath Day Year	3. Time of Death
/Med		Milton Eugel  4a. Facility Name (If not institution, give	. 0.0		45 City Town	t a setting of Box	Decembe		4
Exam	ner	Western Maryland Hospi			4b. City, Town, or	Location of Dea	atn	4c. County of De	
Funera	-	5. Social Security Number 6. Se	7. Age (In yrs	. last birthday)		If Under 24 Hr		Washington 9. B	irthplace (State or Foreign
Directo	-	214 09 1180	2M 20 F 86	Yrs.	Months Days	Hours Mir	). (Month, Da 09.124	2/20 Ma	aryland
and		Usual Residence of Decedent  10a. State 10b. County	10c.C	ity, Town or Loca	tion		l	11	10d. Inside City Limits
Maryl f sho	ō	Md Washi	acton H	t anna	OWN				1 Nes 2 No
r 28a-	rec	10e. Street and Number	THE THE PARTY OF T	yx s	10f. Zip Code			10g. Citizen of What C	
h with	a D	612 N. Mulh	erry St.	0	2174	0		USA	
r deal	Funeral Director	11. Marital Status	12. Was Decedent Ever in 1 Armed Forces?	If Y	as Decedent of His	panic Origin? (	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh	nerican Indian,
36 s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No 19	42-	Yes 2 No	Specify:	rto riioan, etc.)	Specify: W	
ire, Maryland 21215-0036  s. 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "naturel; or Items 23s or 28s-f show other treumatic event, in a Maryland Exist charter as Les robilities at	ed b	15. Decedent's Edu	Year or Dates: 19		nt's Usual Occupat	ion			
215 nin 72	piet	(Specify only highest grad	le completed)	(Give kir	nd of work done du NOT use retired)	iring most of we	orking	16b. Kind of Busines	s/industry
212 d with	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Police	Officer			Federal G	overnment
laryland 2121 2 should be filed within and Mental Hygiene. Is marked other then eurmatic event, in em.	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,	,	
arylandshould be and Mental is marked o	2	Percy Moore Myers					Alice F		
Maryland d 2 should be file th and Mental Hy 77 is merked oth treumatic event		19a. Informant's Name/Relationship (T)	/pe, Print)					r, City or Town, State.	
G, M 1 and 2 Health em 27		Amy E. Myers/Wife	20b.	Place of Dispositi		y St.,	Hagersto	wn, MD 21 20c. Location - City o	740
		1 N Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, cremat	tory or other place,	· •			
	4	21. Signature of Funeral Service Licens			Cemeter			Hagerstown n Funeral	
Balt permit. Departe Importa		> S.Mule S.	مرد	160	1 Pennsy	lvania	Ave Ha	gerstown,	Cnapel MD 21742
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused the dea						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Clarmai	adn	di	210-			Onset and Death
/Medical		resulting in death)	Due to (or as a conse		uy is	nau			i Mollin
Examiner	L	Sequentially list conditions, if any, leading to immediate	Blerdan	N con	comon	er_			1 year
of the state of th	line	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a conse	quence of):					
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68760, % ilicate be executed g physician and as the burial-transit	dical E	L.							
	edic								
Box 6 death certific death certific e attending print for use as	Physician/Me	EDD: 1743 GOODGOIN PROGRAM	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta	ancy	ctopic pregnancy			23d. Date of de	livery
* 0 0 0	sicia	in the past 12 months?  1 Yes 2 No	4☐ Pregnant at time of €		ther (specify)			Month	Day Year
that the deed by the detached	Phy	9 Unknown							
Records, P.O. The law requires that the tae has been signed by the page 2 should be detached.	by	Part II. Other significant conditions con	ntributing to death but not re-	sulting in the unde	ertying cause given	in Part I.		bacco use contribute t	. )
Cord w requir been si	etec								robably 4X Unknown
Division of Vital Records, to attending Physicien: The law requires tatler death.  Director: Affer this certificate has been signed in by the funeral director, page 2 should be a	Completed						24a. Was a autops perfor	sy prior to	utopsy findings available completion of cause of
Vital F icien: Th certificate ector, pag	ပိ	25. Was case referred to medical			2.700		1□ Yes	2X No 1 ☐ Yes	s 2No
of Vita Physicien: this certifica	To B	examiner?	fospital: 1   Inpatient 2	ER/Outpatient	3□ DOA Other:		ath (Check only or		
on of ding Phy h. After thi funeral c		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c Injury a Work?			ence 6 Other (Spe	ocify)
Vision Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	(Wollin, Day 1 ear)	Injury		s 2 No			
Division of Attendati	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street,	, factory, office		28f. Location (S. City or Town	treet and Number or R	ural Route Number,
pital curs all	O	00-0-0-							
Divisi  To the Hospital or Attenwithin 24 hours after dear To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)  1 Certifying Physical Examination	sician: To the best of my kno	owledge, death og ation and/or invest	curred at the time, tigation, in my opir	date and place nion, death occu	e, and due to the curred at the time, d	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)
o the ithin ( o the omple	Mec	29b. Signature and title of certifier	and manner stated.		29c. License r			9d. Date signed (Mont	
F 3 F 8		Mayar 9	suas		028			12 - 2 - 6	
3		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type, Prin		nsylvani	a Aronica		
		manyan g	SHAPT	, (,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1500 1 CI	msylvani wn, MD 2			
- NO. 10 1	ate	31. Date filed (Month, Day, Year)	Registrar's Signa	ature	ingerst.	WII, 1110. Z	1/42		
* Regist	rar	<b>DEC 1.3.2009</b>	Harman 1	CATERIA					

06-09274
Dorothy Neighoff

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Cer	tificate of		ia Meritari	,5	No. 200	6 3987
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last)	y Neighoff			· · · · · · · · · · · · · · · · · · ·	2. Date of Death Month December		3. Time of Death 1850 hrs
		4a. Facility Name (if not institution, give		72	b. City, Town, c	or Location of Dea		4c. County of Deat	
		Sinai Hospital	- <u> </u>		Baltimore			None	
Funeral Director			7. Age (In yrs. la M 2XF 80	ast birthday) Yrs.	If Under 1 Ye  Months Da		_	1925 9. Bi	
any	ŀ	Usual Residence of Decedent  10a State 10b County	10c. City,	Town or Locati	on				10d Inside City Limits
land f show	ö	MD Howard	Ell	licott (			<u>.</u>		1 Yes 2 X No
e Mary or 28a-	Director	10e. Street and Number	•		10f. Zip Code			g. Citizen of What Cou	,
with th	la l	6247 Woodcrest Dr. 11. Marital Status	12. Was Decedent Ever in U.			lispanic Origin? (	Specify Yes or No-		ican Indian, Black,
death	Funeral	1 Never Married 2 Married	Armed Forces?  1 Yes 2 X No			an, Mexican, Puer	to Rican, etc.)	White, etc.	4-0
irs after irral", miner	à	3 Wildowed 4 Divorced  15. Decedent's Education (Specify only	If Yes, Give Year or Dates: v highest grade completed)		Yes 2 X N	o specify ation (Give kind of	f work done	Specify: Whi	
5 72 hou in "nat	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	ost of working lif	e. DO NOT use re			•
003( within giene her tha	dwo	77. Father's Name (First, Middle, Last)		HC	memaker		ne (First, Middle, M	Own Home	! 
Ore, MD 21215-0036 es I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene If item 27 is marked other than "natural", or items 23a or 28a-f she ther transmatic event, the Medical Examiner must be positived at once	Be C	Richard Clingman				Mary Hai		alderi Surrianie)	
21 should be nd Mer is mar	2	19a Informant's Name/Relationship (Ty	pe, Print )					per, City or Town, State	
b, MD and 2 sho lealth and item 27 is	ŀ	John Neighoff/Son 20a Method of Disposition		Place of Disposi	tion (Name of ce		Date	City, MD 20c. Location - City or	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other trammatic event, the Medical Examiner must be potified at once.		1 Yourial 2 Cremation 3 Donation 5 Other Specify:		rematory or oth adowride	je Mem.	Pk. 12-	-09-2006	Elkridge,	MD
Baltimo permit Page: Department o Important:	ŀ	21. Signature of Funeral Service Licens	ee 00 M010	)44 <sup>22. N</sup>	ame and Addres	ss of FacilityHa	cry H. Wi		ily FH Inc.
Physician	$\dashv$	23a. Part I. Enter the disease, or compli	cations that caused the death.	411	2 Old C	Columbia a. such as cardiac	Pike Ell	icott City	MD 21043 Approximate Interval
/Medical		failure. List only one cause on each	h line.						Between Onset and Death
Examiner			Complications of oue to (or as a consequence of	atheros	clerotic	cardiovas	cular disea	se	
The second of the	Je.	if any, leading to immediate cause. Enter Underlying Cause	ue to (or as a consequence of	f):					
	Examiner	(Disease or injury that initiated C.	ue to (or as a consequence of	f):					
'60, rate be executed obysician and ne burial - transi	ia E	d							
60, ate be en shysician ie burial	Medical	X UNPENDED  IF FEMALE:	AMEAUSED, 27, 28a-f, 23c. If yes, outcome of pregr	perME,G86	55, 3/2/07	7 TT		23d. Date of deliver	
of Vital Records, P.O. Box 68760, ling Physician: The law requires that the death certificate be executed. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit	ian/N	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fet	al death 3	Ectopic pregr	nancy		Day Year
Box 687 e death certific the attending ped for use as the	Physician/	1 Yes 2 No 9 Unknown	Pregnant at time of dea  Unknown	ath 5 Oth	ner (Specify)				
.O. F hat the ed by tl	by Ph	Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause	given in Part I.		acco use contribute to	
IS, P quires t en sign uld be c	ted t						1 Yes		oably 4 🗸 Unknown
COFC: law re: has be	Completed						autops perform	y prior to oned? death?	completion of cause of
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach		25. Was case referred to medical			26 Plac	e of Death (Check	1 Yes 2		es 2 No
Vita	To Be	1 🗸 Yes 2 No	ospital: 1 / Inpatient 2	ER/Outpatient				esidence 6 Othe	a l
		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	Approx.		ury at Work? Yes 2 X No	subject u	ow injury occurred nderwent surg	gical
risio r Atten ter deat irector n by th	ficati	2 X Accident Investigatio	28e Place of Injury - At ho	0800 ome, farm, stree			procedure 28f Location (St	reet and Number or Ru	ral Route Number, City
Div spital o	Certification:	4 Homicide determined	(Specify) Sinai H	ospital			Baltimore,	MD 2401 W. E	elvedere Ave.
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certifications after death To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral	Medical	(oncor on)	<ul> <li>To the best of my knowledg</li> <li>On the basis of examination ar</li> </ul>						
To To To Com	Med	29b. Signature and title of certifier	and manner stated.		29c Licen	se number		29d. Date signed (Mo	nth, Day, Year)
		Theodor U.	Kind JR, m	·D.	O.C	.M.E.		December 6, 200	06
0,2	1	30 Name and address of person who de Theodore M. King, Jr., MD.	ompleted duse of death (Item Assistant Medical E		111 Penn S	treet, Baltimo	re. MD 21201		
St	ate	31. Date filed (Month, Day, Year)	32. Raistrar's Signatu	re.				<u> </u>	
Regist		DEC 0 8 20	106 Blown	& April	uli	· · · · · ·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MAMADI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** ALTI MULE MEDICAL am AINIA CUNTER Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 X M 2 □ F 33 none Director 4/10/1973 Gambia Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10b. County Silver Spring 1 ☐ Yes 2 No Md. Montgomery by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Gambia 2305 Shorefield Rd. #232 20902 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Specify: black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cosmetology Barber 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Njie Njie Kenbugurt Momodou Lamin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $\,20902$ 19a. Informant's Name/Relationship (Type. Print) 2305 Shorefield Rd., Apt#232 Silver Spring, Md Sulayman Ndimbalan/cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Family Cemetery 12/3/06 Banjul, Gambia 4 □ Donation 5 □ Other (Specify) 21. Signiture of Funeral Service Licensee 22. Name and Address of Facility Universal Mortuary 411 Kennedy St., N.W. Washington, DC20011 23a. Pant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** BUDD-CMIAZI /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE use . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? res 2 D No 1☐ Yes within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of De (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AU4176435 M17441 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

NOV 28 2006

GREEK

31. Date filed (Month, Day, Year)

32. Registrar's Signature

BRYMORE

21201

		•	For State Registrar	1 10400	State of	Marylan	d / Dep	artmen rtificate	t of H	ealth a		lental Hy		006	39877
		**	Negistrar     Necedent's Name (F	irst, Middle, Last	)			rinoan	0 01 2	Joann		2. Date of De			3. Time of Death
	Physicia		William	Je	ennings	N	orton					Dec 2, 2	2006	Year	6:20am <sup>м</sup>
	/Medic Examin	7	4a. Facility Name (If no					4b. City,	Town, or	Location of	of Death	,		ounty of Dea	th
			235 New H					1	nberl					egany	
40	Funeral Director		5. Social Security Number 216-30-18 Usual Residence of De	30 19	X 2□ F 7.	74	last birthday) Yrs.	If Under Months	Days	If Under	Min.	8. Date of Bir (Month, Da Oct 18	y. Year) , 1932	9. Bir C V	tholace (State or Foreign cuntry)
	land ow			b. County		10c. Cit	ty, Town or Lo								10d. Inside City Limits
	Man,	ķ	MD	Allegan	y		Cum	berlan	d						1 □Xes 2 □ No
	or 28	Olrec	10e. Street and Numbe					10f. Zip						n of What C	ountry?
	ath w	<u>ea</u>	235 New I	Hampshi						21502		2 2		USA	
396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Introprents: If term 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married  3 Widowed 4		12. Was Deceder Armed Force 1 Tyes 2: If Yes, Give Year or Date	s? □ No		Was Deced If Yes, spec 1 ☐ Yes		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		Black, Whi	
200	72 ho	Completed by		Decedent's Edu		Nuice	16a. Dece	dent's Usua kind of wo	al Occupa	ation during mos	t of worki	na		of Business	
2	ithin 196.	nple	Elementary/Seconda	ry (0-12)	College (1-4	or 5+)	life.	DO NOT us	se retired	)				l al a. 4	
7	lled w hygier her th	S	17. Father's Name (Fire				labore	<u>r</u>		18 Mothe	ar's Name	(First, Middle		Indust	ries
$\subseteq$	should be find Mental H marked of urnatic ever	To Be	Paul G.	Norton						Elsi	ie (S	Shanho	tz) No	orton	
, Mar	and 2 sho laith and 127 is m er traum		Patricia N		ype, Print) Wife		235	New	Ham	pshire		e Cumb			MD 21502
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 ii any injury or other tra		20a. Method of Disposi 1 Durial 2 0 4 Donation 5	remation 3 🗆			Place of Dispo cemetery, cre nset Mer			e)		12/5/2006		tion - City or berlar	Town, State
Balti	permit. Departn imports any inju		21. Signature Finer	al Service Liceny	111	111	, 2					me, P.A. ; Cumbe		MD 2150	12
			23a. Parti. Enter the o	disease, or comp	lidations that cau	sed the deat	th. Do not en	ter the mod	e of dying	g, such as	cardiac o	or respiratory a	rrest.	110	Approximate Interval Between
	Physician		Immediate Cause (Fin disease or condition			ano		06	Lu	ng					Onset and Death
-	/Medical Examiner		resulting in death)		Due to (or	as a conseq	quence of):			0					/
	Examine	_	Sequentially list condit	ions,	b	as a consequ	anamer of a								
	led sit	Examiner	Sequentially list condit if any, leading to infine cause. Enter Underlyin Cause (Disease or inju-	ng T	20010 (31	de a ouriesq	paoried dij.								
7	be executed icien and burial-transit	xar	that initiated events resulting in death) Last		c. Due to (or	as a conseq	uence of):								
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89	tificat ng phy as the				<u> </u>										
Вох	The law requires that the death certificate be executed tie has been signed by the attending physicien and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pro	egnanı	23c. If yes, outco 1□Live birth			☐Ectopic pr	egnancy				230	d. Date of de	
о. Ш	e dea	sicia	in the past 12 mo 1 Tes 2 DN 9 Unknown		4☐ Pregnan 9☐ Unknow	t at time of d		Other (sp						Month	Day Year
9.	hat th od by I	P.	Part II. Other significa	nt conditions co	ntribution to deat	h but not res	sulting in the I	ınderivina c	ause nive	en in Part I		23e. Did t	obacco use	contribute t	o the cause of death?
ds,	signe d be c	d by	Takin oktor organica		in in its		, and a	in donying o	acco g.r.			1 🔿	2		robably 4 Unknown
Vital Records,	w require been si should t	Completed										24a. Was	an I	24b. Were a	utopsy findings available
Re	The law ate has page 2:	E C										auto <sub>l</sub> perfo	rmęd?	prior to death?	completion of cause of
		0	25. Was case referred	to medical		·				26. Place	of Death	1 ☐ Yes	20 No	1 🗆 10	s 2□ No
	Ø 12 ×	To B	examiner? 1 ☐ Yes 2⊉No		Hospital: 1 🔲 Inp	atient 2	ER/Outpatie	nt 3 DC	Othe Othe	er: 4 🗆 Nu	ırsing Ho	me 5 Resi	dence 6 [	Other (Spe	ecify)
0 _	ng Ph fter th meral		27. Manner of Death	i ☐ Pending	28a. Date of (Month,	njury Day Year)	28b. Time o Injury	of 2	8c. Injun Work			28d. Describe	how injury o	occurred	
sio	Attending r death. ector: After by the fune	cati	2 Accident	investigation				М		Yes 2		206	Canadaaad	More bases 6	
Division of	or Attendate death Director:	Certification:	4 Homicide	determined	286. Place of	Injury - At h , etc. (Specil	iome, farm, st fy)	reet, factory	y, office			City or To		vum <i>ber</i> or F	ural Route Number,
1	Hospital or 24 hours after the Funeral Direction in letely filled in	3 C	29a. Certifier	Certifying Phy	/sician: To the b	est of mv kno	owledge, dea	th occurred	at the tim	ne, date an	nd place.	and due to the	cause(s) ar	nd manner a	s stated.
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	(Check only 2[ one)	Medical Exam	iner: On the basi	s of examina	ation and/or in	rvestigation	, in my of	pinion, dea	th occurr	ed at the time,	date and p	lace, and du	e to the cause(s)
	within 2 within 2 To the f	Me	29b. Signature and title	of certifier				290	c. License	e number				_	th, Day, Year)
				h	hata	~			D	0033	280		Dec	3,2	200
	V		30. Name and address			of death (Iter									
. 0	Sta	i c	Sunil Gu 31. Date filed (Month,	pta M.D	32. Red	istrar's Sign	625 ature	Kent /	ven	ue Cı	ımbe	rland M	D 215	002	
	Registr		DEC	1 3 200	des	istrar's Sign	A Da								

			For Stata Registrar	State o	of Marylar		artment of F			iene <sub>g. Nó.</sub> -	006	39878
		7	Decedent's Name (First, Middle	a, Last)					2. Date of Deat Month	h		3. Time of Death
	Physicia /Medic	al	Gilbert	Owens					Novembe	r 24	2006	6:15 p <sup>M</sup>
	Examin		4a. Facility Name (If not institution					r Location of Death			inty of Death	
	. , , 8	S.	Washington A				Takoma			_ L	tgomer	
	Funeral		5. Social Security Number	6. Sex 1. ★M 2. F	7. Age (In yrs.		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year)		place (State or Foreig ntry)
	Director	-	252-44-6803 Usual Residence of Decedent		74	113.			8/5/19	32	Geo	rgia
	land ow		10a. State 10b. County		10c. C	ity, Town or L	ocation				1	10d. Inside City Limits
	Mary	to	Maryland Prince	George's	Sp	ringda	le				ĺ	1⊠Yes 2□No
	1 286	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen	of What Cou	ntry?
	th wit		3527 Edwards S	treet			2077	4		Unit	ed Sta	tes
	dea	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-		Race - Ameri Black, White,	
9	or it	y Fu	1 Never Married 2 Marr	ned 1 X Yes	2 □ No		1 ☐ Yes 2 ☒ No					Lack
Ö	urel'.	d by	3 Widowed 4 Divorced	Year or D	Dates: Kor							
7	n 72	Completed	15. Deceden (Specify only higher	t's Education st grade completed)	)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of world	king	16b. Kind (	of Business/In	ndustry
2	withii then	ш	Elementary/Secondary (0-12)	College (	(1-4or 5+) 2		ical Tech			NASA		
<b>Q</b>	be filed within 72 hours after death with the Maryland tal Hygjene.  d other than "natural", or items 23a or 28a-f ehow event, the Medical Examinar must be notified at	ပိ	17. Father's Name (First, Middle,	Last)					ne (First, Middle, I		пате)	
<u>a</u>	id be ental ked ic ev	To Be	Odell Owens,	Sr.				Franc	es Rhoad	ls		
Baltimore. Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mantal Hygiene. Department of Health and Mantal Hygiene. In important: if time 27 is marked other than "naturel", or items 23a or 28a-1 show eny injury or other treumatic event, the Madical Examinat must be notified at ones.		19a. Informant's Name/Relations Lyndon Owens/Wi				ng Address (Street Edwards					
nore.	it. Pages 1 auritment of Hearthant: If item		20a. Method of Disposition  1  ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S				osition (Name of matory or other place coln Ceme				on - City or Tood, M	
Baltir	permit. P Departme Importer eny injur		21. Signature of Funeral Service		ler	2	2. Name and Addre	ss of Facility For	t Lincol	n Fur	neral H	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea						, 1110 2	Approximate Interval Between
8760.	behaviores that the death certificate be executed  Example 1	dicai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	red	quence of):  quence of):  quence of):	Dia	lyesis	Calc	Eal	- Q.	
Division of Vital Becords, P.O. Box 68	To the Hospital or Attending Physicien: The law requires that the death certifical within 24 hours after day.  When the Funerel Director: After this certificate has been signed by the ettending phy completely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregr birth 2 Fet mant at time of nown	al death 3	□Ectopic pregnancy □ Other (specify) _	4		23d.	Date of deliv Month	ery Day Year
ds. P	quires that n signed b	d by P	Part II. Other significant condition	Slave	death but pet re	sulting in the	underlying cause giv	ren in Part I.				the cause of death? bably 4 □Unknowr
tal Reco	To the Hospitel or Attending Physicien: The law re within 24 hours after death.  To the Funerel Director: After this certilicate has bee completely filled in by the funeral director, page 2 sho	e Completed	25. Was case referred to medica	beton	S.	يط.اا		36 Place of Dea	24a. Was a autops perform 1 Yes :	ned? 2½√No	4b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
>	ysici s cer direct	To Be	examiner? 1 ☐ Yes 2 🔂 No	Hospital: 1 🖾	Inpatient 2	☐ER/Outpatie	nt 3 DOA Oth	000	ome 5 Reside		Other (Speci	fv)
ō	g Ph		27. Manner of Death	28a. Date	of Injury nth, Day Year)	28b. Time Injury			28d. Describe ho			97
<u>.</u>	ath.	atio	1 ☑Natural 5 ☐ Pendir 2 ☐ Accident investi	gation	min, Day 7 Gary	injury		Yes 2 □No				
Divis	el or Atte s after de si Directo	Certification;	3 🗍 Surcide 6 🗎 Could 4 🗍 Homicide determ	ined 288. Plac	e of Injury - At I ding, etc. (Spec	home, farm, s ify)	treet, factory, office		28f. Location (Si City or Town	reet and N n, State)	umber or Run	al Route Number,
	he Hospil in 24 hour he Funeri pletely fills	Medical (	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To th Examiner: On the I and mar	ne best of my kr basis of examin nner stated.	nowledge, dea nation and/or i	th occurred at the til nvestigation, in my o	me, date and place opinion, death occu	rred at the time, d	ate and pla	ice, and due t	o the cause(s)
	To To t	W	29b. Signature and title of certifie		Sig	1	29c. Licens	y SCCC			gned (Month,	
CK	0/14		30. Name and address of person	V 7 ((	DUT	Co	Print)	, M	· Bc	Lie	MI	11525
	Sta Registr		31. Date filed (Month, Day, Year, NOV 2 8 20	06 Race	Registrar's Sign	Coer	e e					

		1	For State Registrar	State of Maryla	nd / Depa	artment of rtificate o	Health an	nd Mental Hy	giene	006	39879
	Physicia	an	1. Decedent's Name (First, Middle, La HAZEL FORD	orr ORR			- 5· · · · · ·	2. Date of De Month DECEMI		2 00 6	3. Time of Death
Į	/Medic Examin	er	Aa. Facility Name (If not institution, given Chester River  5. Social Security Number  6. S	Hospital Ce	enter	Chest	or Location of Dertown	-111		unty of Death Kent  9. Birth	place (State or Foreign
	Funeral Director			□ M 2 🕱 F 8 S		Months Day	s Hours	Min. 8. Date of Bir (Month, Date of Mar 8	1923	Cou	yland
	B Maryland a-f show		10a. State 10b. County  MD Kent		ock Ha						10d. Inside City Limits 1X Yes 2 ☐ No
	3a or 28	ii Dire	10e. Street and Number 5797 South Ha	wthorne Ave	•	10f. Zip Code 2166			U.S.	n of What Cou . A .	intry?
336	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show the Modical Examiter most be notified a	by Fur	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 🖫 Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify C		n? (Specify Yes or No Puerto Rican, etc.)		Race - Ameri Black, White, pecify:	
Maryland 21215-0036	be filed within 72 hours after death with the Marylan at Hygiene. All Hygiene. All Hygiene. As other than "natural; or Items 23a or 28a-f show avant, It's Maryled Examiner mast be mailing at	Completed	15. Decedent's E (Specify only highest gr.	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work do DO NOT use ret DETVISO	ne during most o ired)	ousekeep		of Business/Ir Hosp	oital
and	should be filed and Mental Hygie marked othar matic avant,	To Be C	17. Father's Name (First, Middle, Last Olie Ford	)				s Name (First, Middle ie Strad		mame)	
	nd 2 shou lith and M 27 is mar r traumat	-	19a. Informant's Name/Relationship (	(Type, Print) SON )		ng Address (Stre		or Rural Route Numb ock Hall			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic aronce.		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 [  1 ☐ Donation 5 ☐ Other (Special Contents)			osition (Name of matory or other p Cemete		Date 2/9/06		tion · City or T Hall,	
Balti	permit. Departn Importa any inju		21. Signature Juneral Service Lite	MOC	510 11	18 West	Cross	St. Gal	ena,	ohen I	L. Schaech 21635
760, ©	ate be executed  Wedical  Wedical  The burial-transit  We burial-transit	cai Examiner	23a. Partf. Enter the disease, or conshock, or liveart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons	ell Ud equence of): medica equence of):	ler the mode of a	tying, such as ca	Jule no	arrest,	lon	Approximate Interval Between Onset and Death (Section 2015) and the Section 2015 and the Sect
.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy age 2 should be detached for use as the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1  Yes 2 No 9  Unknown		230	d. Date of deliv	very Day Year				
<u>α</u>	luires that the signed by ald be detacted	d by Ph	Part II. Other significant conditions	contributing to death but not i	resulting in the t	underlying cause	given in Part I.		tobacco use	~	the cause of death?
I Records,		Complete						24a. Wa: auto perf 1 □ Yes	s an 2 ppsy ormed? 2) 2 No	24b. Were aut prior to codeath?	topsy findings available completion of cause of 2 No
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 Yo	Hospital: 1 Inpatient 2	☐ ER/Outpatie	ent 3 DOA	Other	of Death (Check only sing Home 5 Res		]Other (Spec	ify)
on of	ding Phys h. After this funeral di	tion: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time ( Injury		njury at Work? □ Yes 2 □ N	28d. Describe	how injury o	ccurred	
Division	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not determine	be Ose Blace of Injury . A	t home, farm, s ecify)	treet, factory, offi	Ce		(Street and Nown, State)	√umber or Ru	ral Route Number,
	a Hospita 124 hours e Funeral letely filler	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	Physician: To the best of my laminer: On the basis of exam and manner stated.	knowledge, dea ination and/or i	ith occurred at the nvestigation, in n	e time, date and ny opinion, death	place, and due to the occurred at the time	cause(s) an	nd manner as ace, and due	stated. to the cause(s)
)	To th withir To th comp	Me	29b. Signature and title of certifier	Klos in	a)	1	1703	6		signed (Month)	ı, Day, Year)
	4		30. Name and address of person who Susan K. Ross	, M.D. 516	Washi	ngton	Ave. C	hesterto	wn, M	ID. 21	620
••	St Regist		31. Date filed (Month, Day, Year)  DEC 1 3 200	22. Registrar's Si	gnature	e e					

		1	For State Registrar	State of Maryla	and / Department Certificate			giene 2 (	06	39880
	Physicia		Decedent's Name (First, Middle, Last	11	0-	0, 200	2. Date of Dea Month		Year	3. Time of Death
The same	/Medic	al -	4a. Facility Name (If not institution, give	street and number)	4b. City. To	own, or Location of Death	11	4c. County	06 of Death	19:07 P.M.
E.	Examin	er	Snow Hill Nursi	vot Rehab.	Center SNO	W Hill		Woi	ccs	to- Count
	Funeral Director		5. Social Security Number 6. Se	7. Age (In yi	rs. last birthday) If Under Y Yrs. Months	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day	Year) 2 2	9. Birthpl Count	lace (State or Foreign   try)
	ט	-	Usual Residence of Decedent	0.7	City, Town or Location		1-17	- ~ ~	1/	Od. Inside City Limits
	death with the Maryland ims 23a or 28a-f ehow r roust be notified at	Ď	10a. State 10b. County	ctor S	11010 Hill					12 Yes 2 □ No
	or 28a	Funeral Director	10e. Street and Number		10f. Zip C	Code		10g. Citizen of	What Coun	try?
	ns 23s	eral	11. Marital Status	12. Was Decedent Ever in	U.S. 13. Was Decede	165 nt of Hispanic Origin? (Sp y Cuban, Mexican, Puerto	pecify Yes or No-	14. Rac	e - America	
98	be filed within 72 hours after death with the Marylan delivygiene.  deli	by Fun	1 Never Married 2 ☐ Married	Armed Forces?  1 Yes 2 HNo If Yes, Give Year or Dates:	If Yes, specif		Rican, etc.)	Specify Specify	ck, White, e	atc.
21215-0036	72 hours natural		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	cation	16a. Decedent's Usual	Occupation	kina	16b. Kind of B	usiness/Ind	Justry
1218	within 7 ene. than "n n Mad	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	ρ (Silve Airid of Work	done during most of work retired)	, and	11.11.	F	. Da. 14
	itled v I Hygie other I	a)	17. Father's Name (First, Middle, Last)		HOUYCTIC	18. Mother's Nam	e (First, Middle,	Maiden Suman	ne)	STOUTER
Maryland		To B	Obje Collin	S Christ	10h Mailing Address /	Street and Number or Ru	W	littic	sid Zin	Cadal
	h ar h ar 7 is treu		19a. Informant's Name/Relationship (T	(Friend)	114 Manle	Street S	NOW H	111.0	nd.	21863
Baltimore,	Pages 1 and nent of Healt int: if item 2 iry or other		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □	200	D. Place of Disposition (Name cemetery, crematory or oth	e of er place)	Date	20c. Location	City or To	wn, State
Itim	ermit. Par epartmen iportant: iy njury		4 ☐ Donation 5 ☐ Other (Specify		Urtis U.M. (	Address of Facility D	2-06 1	SIShop	DUILL	e Ind
8	40 T 9 Q		THU SE	tto	P.O. BO	2331 POCO	10,016 31	ity	nd.	21857
			23a. Part1. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused the de ne cause on each line.	eath. Do not enter the mode	- 4	- 4	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a cons	sequence of):	to scleu	375			4-45
ı	Examiner	<b>.</b>	Sequentially list conditions	b. Due to (or as a cons	Consumos other					
Т	outed d ansit	Examine	Secuer trany list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.	sequence on.					
,092	death certificate be executed e attending physicien and by for use as the bunal-transit	icai Ex	resulting in death) Last	Due to (or as a cons	sequence of):					
9	tificate ig phys as the			d						01-
Box	leath certifical attending phy for use as th	Physician/Med	in the past 12 months?	23c. If yes, outcome of pred 1 Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3 Ectopic pre				ite of delive onth	ory Day Year
P.O.	t the de by the a	hysic	1 Yes 2 No 9 Unknown	9□ Unknown	5 Color (3)00	cay,	7			
	The law requires that the tee by the bas been signed by the bage 2 should be detache	5	Part II. Other significant conditions co	ntributing to death but not	resulting in the underlying ca	use given in Part I.		obacco use con res 2 No		ne cause of death? ably 4 □Unknown
Records,	aw requ s been 2 shoul	Completed					24a. Was		Were auto	psy findings available mpletion of cause of
I Re		Com						rmed?	death?	2 No
Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 □ Inpatient 2	P☐ ER/Outpatient 3☐ DOA	Other	th <i>(Check only</i> o		ner (Specifi	v)
n of			27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year	28b. Time of 28	c. Injury at Work?	28d. Describe			·
Division	eat or:	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - A	At home, farm, street, factory,	1 Yes 2 No			ber or Rura	al Route Number,
á	ital or irs efter		4   Hornicide	building, etc. (Spe			City or Tov			
	To the Hospital or Attenwithin 24 hours efter deat To the Funerel Director: completely filled in by the	Medicai			knowledge, death occurred a nination and/or investigation,					
	To th Withir To th	Me	29b. Signature and title of certifier		1	License number		29d. Date signe		A
			30. Name and address of person who					11/2	, , 0 0	<i>ν</i>
£	3A5		16 04 - Market 31. Date filed (Month, Day, Year)	22 Pomietrar's Si	comoke:	M) 218	351			
*	Sta Regist		NOV 3 0	2006 June	to speck	,				

Certificate of Death

3. Time of Death

2200

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Yes 2 No

Birthplace (State or Foreign Country)

Maryland

Year

06

Wicomico

4c. County of Death

USA

Specify:

Hebron, MD

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No

Year

Month

14. Race - American Indian, Black, White, etc.

white

Teamsters Local 557

28

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

614

32. Registrar's Signature

M. I HIMMARAYAPRA

NOV 3 0 2006

31. Date filed (Month, Day, Year)

**ORIGINAL** 

B

00 60515

EASTERN STARE DR SALISBURY MD4804

DHMH 17 Rev 1/2001

State

Registrar

06-	090	007		
	r 1		D-1	

6-09007						Black Ind				
label M. Price		Stat	e of Maryland				nd Mental	Hygiene	0.0	
		- For State Registrar		Cer	tificate c	of Death		Re	eg No 201	J6 3988
Physicia		Decedent's Name (First, Middle,L	ast)					2. Date of Deat		3. Time of Death
Medical Examin	er	Mabel	Maggie	Pri	ce			Month November	Day Year 26, 2006	1001 hrs
Ma		4a. Facility Name (if not institution, o	give street and number)			4b. City, Town, o	r Location of De	ath	4c. County of Dea	ath
		I-95 SB at mile marker 1	05.7			Elkton			Cecil	
Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. la	ast birthday)	If Under 1 Ye			h(MM/DD/YYYY) 9. E	
Director		238-62-5753 1	M 2X F	6	6 Y	Months Da	ys Hours N	/in 11/23	3/1940	eign North Country) Carolina
	ŀ	Usual Residence of Decedent						1-1, 10	/ = = = -	Carolilla
any	Γ	10a. State 10b. County		10c City,	Town or Loca	ation				10d. Inside City Limits
nd show	١	DE New (	Castle	N	ewark					1 Yes 2 X No
Maryland 28a-f show d at once.	섨	10e. Street and Number	JUDGIC		CWALK	10f Zip Code		10	Og Citizen of What Co	ountry?
or or	Director	19 Sandalwood	Drive,	Apt.	1	10	713		USA	
vith the s 23a		11 Marital Status	12. Was Decedent	~				Specify Yes or No-		erican Indian, Black,
eath w	Funeral	1 Never Married 2 Marri	ed Armed Forces			Yes, specify Cuba			White, etc	
ter de		3 Widowed 4 X Divorce	1 Yes 2 ed If Yes, Give Year	X No	1	Yes 2X N	o specify		Specify: W	hite
IIS af	Completed by	15 Decedent's Education (Specify	or Dates:	npleted)		ent's Usual Occupa	ation (Give kind o		16b. Kind of Busines	
2 hou	ᇎ	Elementary/Secondary (0-12)	College (1-4 or	5+)	during	most of working life	e. DO NOT use r	retired)		
)36 hin 7 e than	힐	12	1			Homema	ker		Home	
5-0036 led within 72 hours a Hygiene other than "natural the Medical Examin	ᇊ	17. Father's Name (First, Middle, La	st)		<del></del>		18.Mother's Na	me (First, Middle, M	Maiden Surname)	
21215-00 uld be filed with Mental Hygien marked other c event, the M	Be (	Alonzo Allen					Carr	ie Osbo	rn	
2121 Muld be fi Mental marked c event.		19a. Informant's Name/Relationship	(Type, Print )		19b Maili	ng Address (Stre			ber, City or Town, Sta	ite, Zip Code)
AD 2 sho	T	Mark E. Price	e - Son		403	Blacks	tone R	Road, Ne	wark, DE	19713
imore, MD 2121 Pages I and 2 should be filment of Health and Mental I tank: If tien 27 is marked or other traumatic event.	ı	20a. Method of Disposition			Place of Dispo	osition (Name of ce		Date	20c. Location - City	
OF ges I at of I other	-1	1 X Burial 2 Cremation		ate Un	rematory or o	ill Cen	ne   1	2/1/06	Kennet	t Sq, PA
Baltimore, MD 21215-0036 bernit Pages I and 2 should be fited within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other than nijury or other traumatic event, the <u>Medica</u>	-	4 Donation 5 Other Spec				Name and Addres				
Baltimore, MD 212 permit Pages I and 2 should bu Department of Health and Ment Important: If item 27 is mark		rout It	ens CCO	442				Home o	f Newark wark, DE	
Physician	$\dashv$	23a. Part I Enter the disease, or co	molications that caused	the death.	Do not enter	the mode of dvino	Laski a. such as cardia	Hwy Ne	wark, DF. est. shock, or heart	19713 Approximate Interval
/Medical	-	failure. List only one cause on	each line			, ,	,			Between Onset and Death
Examiner	1	Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries  Due to (or as a cons		f\-					Dodan
	-		h	oquerioe o	17.					
agen. o at.	힐	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence o	f):					
	盲	cause. Enter Underlying Cause	с.							
sit sd	Examiner	events resulting in death) Last	Due to (or as a cons	equence o	f):					
executed an and al - transit	leal leal		d							
a a e	힔	UNPENDED	AMENDED							
68760, certificate be nding physicia	ξ	IF FEMALE: 23b Was decedent pregnant in the	23c If yes, outcom	ne of preg		etal death 3	Ectopic pred	nanov	23d Date of deliver	Day Year
ox 687 eath certific attending p	ciar	past 12 months?	4 Pregnant at	time of de	oth -	etal death 3 Other (Specify)		griaricy	WOTH	Day Teal
Box e death c the attented for us	Physician/Med	1 Yes 2 V No 9 Unkno	wn 9 Unknown			Strict (Speeding)				
that the detached		Part II. Other significant condition	s contributing to deat	h but not re	esulting in the	underlying cause	given in Part I	23e Did to	bacco use contribute t	to the cause of death?
, P.O.	<u>چ</u>							1 Yes	2 No 3 🗸 Pr	obably 4 Unknown
ords,	Completed	-						24a Was a		autopsy findings available
law law has t	힏							autops perfor	med? death?	completion of cause of
tal Rec rian: The l certificate	<u>آ</u> ق							1 ✓ Yes 2	2 No 1 🗸	Yes 2 No
Vital ysiciau: his certif	Be	25. Was case referred to medical examiner?	Hospital:				Other Nur			
Physical directions	의	1 Yes 2 No 27. Manner of Death	I Inpatie	ent 2	ER/Outpatier 28b Time of				Residence 6  Oth	er Scene
Division of Vital Records, rate death or Attending Physician: The law requirers after death at Director: After this certificate has been sited in by the funeral director, page 2 should be	崩	1 Network	28a. Date of Inju (Month, Day.) Nov 26, 2006		0948 hrs		ury at Work? Yes 2 ✓ No		struck by auto	
SiOI Attended death ctor:	Ĭġ	2 ✓ Accident 5 Pending Investig	ation					201		-
Divisipital or At ours after deral Direct filled in by	Certification:	3 Suicide 6 Could n	ot be			eet, factory, office	building, etc	or Town, St	tate)	Rural Route Number, City
Division Hospital or Attent 24 hours after death Funeral Directors	١٥	4 Homicide	(0,000,00)						e marker 105.7, Elk	
Division of Vital Records, P.O. Box 68760, no the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. It is certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	ca	(Check only	ician: To the best of mer:On the basis of exa							
To the within.	Medical		and manner stated	alion a						
	2	29b Signature and title of certifier					se number		29d Date signed (M	
		Yanule Wishall	nen				.M.E.		November 27, 2	
10	Ī	30. Name and address of person wh		,		44.5		14D 04051		
10		Pamela E. Southall, MD				11 Penn Stree	et, Baltimore	, MD 21201		
Sta		31, Date filed (Month, Day, Year)  DEC 0. 1 200	2. Registra	ır's Signatu	ire Shau	No.				
Registi	έľ	DEO IVI ZUI	IU ALIEUR	30			_			·

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Year Pear1 Pearson November 30 2006 4b. City, Town, or Location of Death 4c. County of Death St. Inigoes

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. St. Mary's 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months 1 □ M 2 🗓 F 10 - 7 - 1935Virginia

Decedent's Name (First, Middle, Last) **Physician** Audrey <u>11:11</u> a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) Examiner 49169 Trapp Road 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Director 579-46-8640 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD St. Mary's St. Inigoes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 49169 Trapp Road 20684 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 등 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Clerk Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cloyd Jones ဥ Maude Elizabeth Jonas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret McMorrow/Daughter 4530 13th Ave., SW, Naples, Florida 34116 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery | 12-5-2006 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 21. Signature Princeral Service Icensee

Edward N. Brinsrield, Jr. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279 M00052 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 20mon 4h Immediate Cause (Final disease or condition resulting in death) Physician Luna ance /Medical Due to ( s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the series Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy pertormed res 2 1□ Yes 25. Was case referred to medical 26. Place of Death Check onl one Hospital: 1 | Inpatient Other: 1 Tes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Medical Certification: To 4 Nursing Home 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral L 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50686

State Registrar

DHMH 17 Rev 1/2001

DEC 0 5 2006

Gurdeep S. Chhubra, md

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. Ne. UUD Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) HOGE **Physician** 10:15 PM ANDREW 11 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner CIR PRINCE CAEORCIES HOSP CHEVERLY GEORGE'S If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) i Funeral 1**⊠**M 2□F Months Days Hours 57 517-66-7778 5-30-49 Washington, DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show The Modical Examiner must be notified at 1 X Yes 2 □ No WASHINGTON Director D. C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? LUTHER KING 20032 USA S.E. MARTIN 4660 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: BLACK δ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education fy only highest grade completed) 16a. Decedent's Usual Occupation (Specify only highest (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 10th unknown Sanitation Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filment of Health and Mentai Heart: if item 27 is marked ottury or other traumatic even Walter William Poge Daisy Yorboro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5449 16th Avenue #201 Hyattsville, Maryland, 20782 19a. Informant's Name/Relationship (Type, Print) LaKisha Poge/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State important: if any injury o once. Chesapeake Crematory 11-17-2006 4 □ Donation 5 □ Other (Specify) Beltsville, Maryland 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 21. Signature of Funeral Service Licenses 3447 14th Street, N.W. Washington, D.C. 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FATAL CARDIAC ARRHYTHMIA **Physician** /Medical Due to (or as a consequence of) Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner UNG physician ar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending part for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 □ No 3 Probably 4 □Unknown as been signal Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificete ha 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 3□ DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D52865 11-10-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEVERLY, MD HOSPITAL FIGARO(ME 3001 K. MICHAEL 31. Date filed (Month, Day, Year) NOV 2 8 2006 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 11 2006 1:41p Paul Michael Peterson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring, Maryland Montgomery 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. ate of Birth 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Pay, Year) 56 1 M 2 □ F 50 577-74-5609 Washington, DC Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or liems 23a or 28a-f show any hijury or other traumatic event, the Medical Examiner must be notified at once. 1\_Yes 2□No Directo Maryland Prince George's Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 8224 Brushy Ridge Road #1E 20724 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Counselor Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Barbara Kenney Basil Peterson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8224 Brushy Ridge Rd. #1E Laurel, Maryland, 20724 Rosie Peterson Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-25-2006 |Landover, Maryland Harmony Memorial 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC.
4308 SUITLAND ROAD SUITLAND, MD 20746 21. Signature of Funeral Service Licensee 1 / lan 23a. Part1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Gause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) **Examiner** olu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and the burial-tran Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No 2 □ No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA Date of Injury 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 19563 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H'e 1500 Holy cruss Kairer C alenn

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 28 2006

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician  $P^{M}$ James Henry Pettiway 11 26 06 7:16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince Georges If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑**M 2□F Days Hours Min Yrs. Director 419-22-6356 83 11 19 23 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Directo Prince Georges Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or items 23a 5605 South Marwood Drive 20772 Funeral <u>United States</u> be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 43-45 1 ☐ Yes 2 💢 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) State of New York 10 Civic Service Employee traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should be filteen of Heelth and Mental H tant: If Itam 27 is marked oil Henry Pettiway Littie Bell Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma L. Pettiway/Wife 5605 South Marwood Drive, Upper Marlboro, MD 20772 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Anemoval from State ö permit. Page Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Memory's Garden Ceme 12-02-06 Albany, NY 22. Name and Address of Facility Strickland Funeral Services, P.A 21. Signature of Funeral Service Licensee ric D. Strice 6500 Allentown Road, Camp Springs, MD 20748 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pheumonia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of) Examiner il or Attending Physician: The law requires thet the death certificate be executed after death.

after death.

The cate: After this certificate hes been signed by the ettending physicien and binecyte: After this certificate speen signed by the ettending shysicien and binecyte after the second director, page 2 should be detached for use as the buriat-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1☐Live birth 2 Fetal death 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 4☐Pregnant at time of death 1 Yes 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ ₩€ 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 peatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ţ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD H0042445 November 27 2006 HH10 Michael Pinentelino 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 POST OFFICE ROAD, 1-A WALDONF, MD 20602

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 9 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

39888 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year November 23,2006 1:55 PM Physician Annie Lee Price /Medical 4b. City, Town, or Locetion of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Prince Georges Hyattsville Sacred Heart Nursing Home | Honder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 24, 1914 5. Social Security Number Birthplace (State or Foreign Country)
 NC 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 🛣 F 92 Yrs. Director 244-30-7285 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylend 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show Department of Health end Mentel Hygiene. Important: or items 23s or 28s-1 show any Injury or other traumstic event, the Medical Examiner must be notified at 1X Yes 2 □ No by Funeral Director PG Fort Washington Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Pates Drive 20744 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 StNever Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specity: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Cook Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sam Price Bleaker Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 20 Pates Drive Fort Washington, 20b. Place of Disposition (Name of competery, crematory or other place) Md Date Janice Hopkins/niece 20744 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 11/30/06 Suitland, Md. 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 nue Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use es the bunal-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, C roni Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Tyes 2 No ģ pe 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1. Yes 2 0 No 1 Yes 2 No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺ No Certification; To this After this funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending investigation 2 🗆 No after death. 2 Accident within 24 hours after death

To the Funeral Director: /
completaly filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DARNES ROAD COWIN. 202 NOV 2 9 2006 32. Registrar's Signature

Registrar DHMH 16 Rev 6/95

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0436 M 30 06 HAROLD CHELTON POWERS /Medical 4c. County of Death . 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Hounica SAKIBUNA Regional medica 10105449 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**X**M 2□ F Yrs New Jersey January 23, 1957 Director 155-56-8867 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland <u>Princess\_Anne</u> Somerset 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code items 23a or 7 21853 USA Funeral 29654 Scotts Blvd. - Apt. B 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, GiveXX Year or Dates: 1 ☐ Never Married 2 ☐ Married ö Maryland 21215-0036 1 ☐ Yes 2√No White ģ Specify: 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seafood 10 Waterman marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked of any injury or other traumatic ev Harold White Powers Shirley Jane Evans ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u> 26728 John Nelson Lane - Crisfield, Maryland 21817</u> Tammy Powers (Wife) timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2/Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/02/2006 | Salisbury, Maryland Salisbury Crematory 22. Name and Address of Facility Bradshaw & Sons Funeral Home 21. Signature of Funeral Service Lepts Baj Mary Beth Bradshaw-Pruitt Crisfield 306 W. Main St Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician SCVO /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 1 □ Yes 2 □ No 9☐Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 □ Yes Completed Morbid Ossilt 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year)

30/06

St. Salisbury MD 21801

State Registrar Christopher

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 E. Carrol

32. Registrar's Signature

		* -		partment of Health and		_	20001
		= State RegistrarAACO HEALTH DEPT. 12/6	5/06 CMH C	ertificate of Death	R	eg. No.	39891
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	To	Madison M. Proctor, Jr.		Vivian	J. Batte	<del>erfield</del> Bu	tterfield
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and tealth om 27 ther tr		Rosanne Proctor (Wife)  20a. Method of Disposition	No.	8 Mountain Top Dri		POLIS, MD 2 20c. Location - City or	
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Maryland 21215-0036	shouls nd Me mark imath	Ţ	19a. Informant's Name/Relationship		19b. Mai	ling Address (Str			ber, City	or Town, State, Zip	Code)
Š	alth a 27 is 27 is r trau		Perlita B. Pen	afiel (Wife)	816	Square	Nail Cour	t, Odent	on,	MD 21113	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any fiultry or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Pamous from State	20b. Place of Disp cemetery, cr	oosition (Name o ematory or other	f place)	Date	20c. l	_ocation - City or To	own, State
Ĕ	Pag ment ant: I		4 Donation 5 Other (Speci		Hillcres			-27–2006	Ann	apolis, l	MD
ga H	Depart Import any Inj once.		21. Signature of Funeral Service Lice	nsee ///		22. Name and Ad Hardest	y Funera	1 Home,	P.A.		
	20 = 8 Q		200 Ports Enter the discourse or con	could be applied to the could be	n doath. Do not o	_12_Ridg	gely Aven	ue, Anna	poli	s, MD 214	O1 Approximate
н			23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	a death. Do not e	nter the mode of	dying, such as can	L (	The st,	ver	Interval Between Onset and Death
9	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a c		ari	RU	may 1	V	eur	co year
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ő,	oe exe cian a		resulting in death) Last	Due to (or as a c	onsequence of):						
6876	cate b	Physician/Medica	•	_d							
× 6	certifi ding l	/Me	IF FEMALE:	23c. If yes, outcome pf	pregnancy					23d. Date of deliv-	erv
Box	leath atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 2 [ 4 ☐ Pregnant at tirr		☐Ectopic pregn☐Other (specify				Month	Day Year
o.	t the c by the achec	hysi	9 Unknown	9□ Unknown							
S, P	The law requires that the death certificate be ate has been signed by the attending physicis agge 2 should be detached for use as the but	by P	Part II. Other significant conditions	contributing to death but r	not resulting in the	underlying cause	e given in Part I.	23e. Dio	l tobacco	use contribute to t	he cause of death?
ord G	equire en si	ted t						_ 1	Yes	No 3□ Prol	bably 4 ∐Unknown
Record	law ras be	Completed						24a. Wa	opsy 4	prior to co	opsy findings available impletion of cause of
	: The	Con						1 Yes	formed?	death? 1 ☐ Yes	2□No
Vital	Physician: The law r this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			Other:	Death (Check only			
ō	Phys r this ral di	-: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 Inpatient	28b. Time	of 28c.	4 □ Nursin Injury at Work?	g Home 50 Re 28d. Describ		6 □Other (Special ury occurred	fy)
Division	Attending F r death. ector: After by the funer	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	'ea <i>r)</i> Injury		Work? 1 ☐ Yes 2 ☐ No				
Vis	er dea	ifica	3 ☐ Suicide 6 ☐ Could not be determined		- At home, farm, s	treet, factory, of	fice		(Street a	and Number or Rurate)	al Route Number,
	ital or rs afte ral Dii led in	Cert									
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate hy completely filled in by the funeral director, page		(Check only 2 Medical Exa	hysician: To the best of r	kamination and/or						
	o the ithin 2 o the	Medical	one)  29b. Signature and title of pertifier	and manner state	J.	29c. Lid	cense number		29d. D	ate signed (Month,	Day, Year)
	F 3 F 8		Michal	8 Deto	war	7 / 1	) 21	438	<b>^</b>	VVV 2	2006
			3/1 Name and address of person (who	completed cause of deal	th (Item 20a) (Typ	e, Print)	- 11		V		
_	15		MICHAEL.La	a BUTTOM	44) D	Exerse	HIGH O	VAY IT	NNI	Your IV	10 21401
-	Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's	Signature	book		,			

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 20 2006 DAVID ROBERT PAVLICK NOVEMBER 11:00 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TALBOT 25 N. HARRISON ST. EASTON If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) SEPT. 10, Birthplace (State or Foreign Country) Days Year) Hours 1**X**M 2□F Yrs. PA 1964 163-46-6679 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ▼No ANNE ARUNDEL **EDGEWATER** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 17 HUNT CLUB COURT 21037 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ CONSTRUCTION MANAGER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ROBERT PAVLICK DOLORES BROZENA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELAINE K. PAVLICK/WIFE 17 HUNT CLUB COURT, EDGEWATER, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Lakemont Memorial Gardens 11/25/2006 Davidsonville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee GEORGE P. KALAS FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Asphyxia Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEVERE DEPRESSION Due to (or as a consequence of) ATTOMOPROVED BY MEDICAL EXAMINER Squardially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): CE THIC IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🏋 No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Tother (Specify) RENTAL Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 X Yes 2 No PROPERTY 28d. Describe how injury occurred PROPER
Subject secured plastic wire ties 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year)

1 ☐ Yes 2 No

6 Could not be determined

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

apartment

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

apartment

28f. Location (Street and Number or Rural Route Number, City or Town, State)

A HARRISON ST

A STON

A D 21 61

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

around his neck

29d. Date signed (Month, Day, Year)

Examiner The law requires that the death certificate be executed physicien a Box 68760 attending for use as use Division of Vital Records, P.O. page 2 Attending Physician: After death. ō

Physician/Medical

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Completed

Be

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1 Natural

2 Accident

3X Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and the of certifie

Certification:

Medical

Physician

/Medical

Examiner

10a. State

MD

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**Funeral** 

Director

Worle 23a or 28a-f should at

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permit. Pages 1 and 2 should be filed within 72 hours after deel Department of Health and Mental Hygiene. Important: if Item 27 ie marked other the any injury or other trainment.

**Physician** 

/Medical

within 24 hours after death To the Funeral Director: completely filled in by the Hospital ihe.

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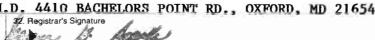
State Registrar

CLAUDE KOPROWSKI M.D. 31. Date filed (Month, Day, Year)

5 Pending

investigation

6 Could not be



nanh

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



27 2006

Fnd 11/20/2006 Fnd 11:11#

			For State	•		d / Depa		lealth and M	lental Hygi	ene	-	398	94
			Registrar	-		Cel	lilicate of	Dealli	2. Date of Death	g. No.		3. Time of	Death
	Physicia	an	1. Decedent's Name (First, Middle, Last)  The1ma Po	ston				i	Month O	Day 24	2006	9:35	
	/Medic		4a. Fecility Name (If not institution, give str				Ah Cihy Town o	r Location of Death		· · · · ·	ounty of Death	2.55	
	Examin	er	Magnolia Center				Lanhan				ince (	eora	es
			5. Social Security Number 6. Sex		a (In vrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth				
	Funeral Director			12XIF 90		Yrs.	Months Days	Hours Min.	(Month, Day, 9/22/]	907	Viro	lace (State o try) (inia	
		1	Usual Residence of Decedent										
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside Ci	
	Mar iffed	호	D.C.		Was	hingt	on					1 🗀 Yes	21 No
	n the	le	10e. Street and Number				10f. Zip Code		10	g. Citize	of What Coun	try?	
	23a c	Funeral Director	4917 Foote Stree	t Nortl	heas	t	20019		Ţ	Jnit	ed Sta	ites	
	deal deal	ner	11. Marital Status	. Was Decedent E Armed Forces?	Ever in U.S	S. 13. \	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,		
<u> </u>	or Ite	교	1 Never Married 2 Married	1 ☐ Yes 2 ☒N If Yes, Give	10		1 ☐ Yes 2 🔯 No		, , , , ,	Si	pecify: B1a		
3	ours	d by	3 AWidowed 4 Divorced	Year or Dates:									
ה ה	72 h Inatu	Completed	15. Decedent's Educa (Specify only highest grade of	ition completed)		16a. Deced (Give	dent's Usual Occup kind of work done	oation during most of works d)	ing 1	6b. Kind	of Business/Inc	dustry	
7	han han	μ	Elementary/Secondary (0-12)	College (1-4or 5	+>					D 0	Dubi	ia c	ahoo 1
٧ :	should be filed within 72 hours atter death with the Maryland of Mental Hygiene. They was a considered of the marked other than "naturel", or flems 23s or 28s-f show marked other than "naturel", or flems 23s or 28s-f show matic event. It as Medical Exercises must be notified at	ပိ	UNKNOWN  17. Father's Name (First, Middle, Last)			Teac	her's A	18. Mother's Name	First Middle M		· Publ	10 5	211001
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<u> </u>	d Me nark natic	ပ	19a. Informant's Name/Relationship (Type	Drint)		10h Mailir	a Address (Street	and Number or Rura				Code)	
2	d 2 s th an 7 le i treui		Elinor McCollum/					Capita1					12
Ď.	1 an Heal em 2		20a. Method of Disposition	110100	20b. Pf	ace of Dispo	sition /Name of				tion - City or To		
Dallillor	ages nt of t: If it		t Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	- 1		natory or other place		9/06 H	ron	twood	MD	
	it. P		21. Signature of Funeral Service Licensee		F1		Name and Addre		3700 1		O H St		NE.
0	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 le markad any injury or other treumetic evonce.		KIM A HOM	2.	1011			ry Funer	al Home				
		_	23a. Part1. Enter the disease, or complications, or heart failure. List only one								Sir v De v	Approximate	0
			shock, or heart failure. List only one Immediate Cause (Final									Interval Bet Onset and I	ween Death
	hysician /Medical		disease or condition resulting in death)	Aspira			umonia						
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0	ie law requires that the death certificate has been signed by the attending physge 2 should be detached for use as the	led											
Š	esn.	N/Z	23b. was decedent pregnant	c. If yes, outcome			Ectopic pregnanc	v		230	I. Date of delive	*	
0	deat te att	sick	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at			Other (specify)	,			Month	Day 1	Year
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_ _	ng P fter t inera	on:	27. Manner of Death 1   ↑ Natural 5 □ Pending	28a. Date of Injur (Month, Day	ry y Year)	28b. Time of Injury	Wo	rk?	28d. Describe ho	w injury o	ccurred		
<u> </u>	Attending or death. ector: After by the fune	catl	2 Accident investigation					]Yes 2□No	001 1			10 . 11	
DIVISION OF	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc	ury - At ho c. <i>(Specif</i> y	me, farm, str ')	eet, factory, office		28f. Location (Str City or Town		iumper or Hura	Houte Num	per,
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	o the	Medi	29b. Signature and title of certifier	and manner on			29c. Licens				igned (Month,		
	⊢ ≯ ⊢ ŏ		MUNIC				D	48213		09	-28-	200	6
			30. Name and address of person who com	noleted cause of d	eath (Item	23a) (Type	Print)				~		
	2	,	Neelam Asho		410	74	th Ave	48213 - land	overt	Pills	. MD	207	84
	Sta Registi		31. Date filed (Month, Day, Year) <b>DEC 1 3</b> 2006		ai s oignai	do	will						

			State of Maryland / Depa 1- State RegistrarAmend #26 PER PHYS 11/30/06 Cer	rtment of Health and Mental I tificate of Death	Hygiene 006 39895
	Physici		1. Decedent's Name (First, Middle, Last)  Francis Earl Reidy, Sr.	2. Date of Month	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Civista Medical (core)  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death  La Plata MD  If Under 1 Year If Under 24 Hrs. 8. Date of	4c. County of Death  Charles  Birth  9. Birthplace (State or Follow)
	Director		577-18-4730 1X <sup>™</sup> 2□ F 86 Yrs.		n <sup>3</sup> 23,1920 Washington
	h the Marylar or 28a-f ehow or cutified at	irector	10a. State         10b. County         10c. City, Town or Loc           MD         Charles         La Pl           10e. Street and Number	ata   10f. Zip Code	10d. Inside City Limits  1
36	be filed within 72 hours after death with the Maryland nat Hygiene. ed other then "naturel", or Iteme 23a or 28a-1 ehow event, the Medical Examinar must be notified at	by Funeral Director	Armed Forces? If	20646  Vas Decedent of Hispanic Origin? (Specify Yes or Yes, specify Cuban, Mexican, Puerto Rican, etc.  ☐ Yes 2 No Specify:	USA  14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036	d within 72 hou giene. Ir then "nature Ine Mudical E	Completed	(Specify only highest grade completed) (Give in the complete of the complete o	lent's Usual Occupation kind of work done during most of working IO NOT use retired)  OTO Engraver	16b. Kind of Business/Industry  Newspaper Co.
/land	2 should be filed and Mental Hygis Is marked other raumatic event, III	To Be C	17. Father's Name (First, Middle, Last) Frederick C. Reidy	18. Mother's Name (First, Mic Mary O'Call	
Baltimore, Mary	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 Is marke any Injury or other traumatic QDCS.		Francis Reidy, Jr./Son  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  304  20b. Place of Disposition State St. Ign	atius Cem. 12/2/06	
Bal	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	Name and Address of Facility AREHART - ECHOLS FUNE 211 St., Mary's Ave- arthe mode of dying, such as Pardiac or respirato	
8760,	Examiner	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	nema.	
P.O. Box 68	ath certific attending p for use as	Physiclan/Mec		Ectopic pregnancy Other (specify)	23d. Date of delivery  Month Day Year
rds, P.	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the ural through the significant conditions with acquired Vert	- 0 A 17	old tobacco use contribute to the cause of death?
al Reco		Completed by		a	Vas an utopsy findings available prior to completion of cause of death?
Division of Vital Records,	To the Hospital or Attending Physician: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner?  1	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	Residence her (Specify) her (Specify)
DİVİ	F S S		4 Homicide determined 200. Flace of my knowledge, death	City or occurred at the time, date and place, and due to	on (Street and Number or Rural Route Number, Town, State) the cause(s) and manner as stated.
	To the Hospital within 24 hours a To the Funaral Completely filled	Medicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or invand manner stated.  29b. Signature and title of certifier	restigation, in my opinion, death occurred at the tie  29c. License number  D 00 5 4 \$ 2 0	29d. Date signed (Month, Day, Year)
À	RLit		30. Na e and address of person who completed cause of death (Item 23a) (Type, I Tam I Ko. A. Brycht 12070 C	Print) line (enter, Suite	11-28-06 100 Walderfind 20602
	Sta Regist		31. Date filed (Month, Day, Year)  NOV 3 0 2006  32. Registrar's Signature	hack	

DHMH 17 Rev 1/2001

feidy, Francis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [ ] [ ] 5 39896 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Dec. 4, 2006 Ann Ridder 2:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett County Memorial Hospital Oakland Garrett 
 If Under 1 Year
 If Under 24 Hrs.

 Months
 Days

 Hours
 Min.

 Dec. 16, 1927

 Pennsylvania
 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F 219-46-1806 78 Yrs Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Garrett Oakland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 Funerai 1643 Silver Knob Road death v 21550 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Dental Practice Pages 1 and 2 should be filed an nent of Health and Mental Hygic ant: if Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Loren Τ. Farmer Harriett Grim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy E. Ridder/Daughter 1727 Silver Knob Road, Oakland, Maryland 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ites
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) WVU Human Gift Reg'ty 12/4/06 Morgantown, WV 21. Signat re Fune a Fervice Licem ee 22. Name and Address of Facility 32 S. Second St. Stewart Funeral Home Oakland, MD 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 Years ONGESTIVE /Medical Due to (or as a consequence of): Examiner ULMONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or infury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown Division of Vital Records, P. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an page 2 s certificate 1 ☐ Yes 2 No r: After this certification of funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 1 ☐ Yes 2 ☑ No 1. Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification; To 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Tes 2 No 2 Accident investigation Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 29a. Certifier Z | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

20

State

31. Date filed (Month, Day, Year)
DEC -

completed cause of death (Item 23a) (Type, Print)

311

32. Registrar's Signature

2006

				epartment of Health and Mental Hygiene 006 3989 Certificate of Death Reg. No.	97
ì	Physicia		1. Decedent's Name (First, Middle, Last)  John Ben Reed	2. Date of Death Month Day 29, 2006 3. Time of Death November 29, 2006 10:40	
1	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death	
	LAGITITI	٠. ا	Laurelwood Care	Elkton Cecil	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 217-09-5005 1 4 2 F 87 Yr	Months Days Hours Min. (Month, Day Year) Country)	reign
	and *		Usual Residence of Decedent           10a, State         10b, County         10c, City, Town or 10c.	or Location 10d. Inside City Li	imits
	after death with the Marylan or Items 23e or 28e-f show of references	0	MD Cecil North	Fast	] No
	28a	Funeral Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?	
	3a or		520 S. Main St.	21901 U.S.A.	
	death	ner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.	
21215-0036	hours after death with the Maryland tural', or Items 23a or 28a-f show al Exardinat ittust be collified at	by	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No If Yes, Give Year or Dates: 1940 S	1 Yes 2 No Specify: Specify: Specify: White	
2-0	"natural",	eted		ecedent's Usual Occupation live kind of work done during most of working	
21	s within 72 hours a jiene. Jene. r than "natural", o	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	fe. DO NOT use retired)	
			10 –	Telegrapher Railroad	
Maryland	d at a	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)	
ž	s 1 and 2 should it Health and Menitem 27 is marketother traumatic	70	Theodore W. Reed  19a. Informant's Name/Relationship (Type, Print)  19b. Name/Relationship (Type, Print)	Rosanna Reed  **Aailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Ma	12 A A A			712 Summer Hill Dr., Phoenix, MD 21131	
	ten 2 item 2 other			isposition (Name of crematory or other place)  Date  20c. Location - City or Town, State	
пOп	00		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	December	
Baltimore,	# 문문급 .		21. Signal service Licensee	22. Name and Address of Facility	
ä	Depermination of the permination		Neo	Andrew G. Gee Funeral Home	
	*		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	259 E. Main St., Elkton, MD 21921  Approximate Interval Between	n
1	Physician		Immediate Cause (Final disease or condition	- Smaru CEU	,h
die de	/Medical		resulting in death)  Due to (or as a consequence of		
30	Examiner		Sequentially list conditions, b		
	ed sit	lne	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying Cause (Disease or injury		
	and and	Examln	that initiated events c. resulting in death) Last Due to (or as a consequence of		
68760,	ate be executed hysician and the burial-transit	calE			
687	ficate p phys	edic	0.		
Box	he death certifical the ettending phy ched for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)   23d. Date of delivery  Month Day Year	
P.0	that the de ned by the e detached f		Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death	1?
of Vital Records,	9 D 9	ed by		1 Yes 2 □ No 3 □ Probably 4 Dunkn	iown
000	s been s s should	ompleted		24a. Was an 24b. Were autopsy findings avail	lable
Ä	The lay	ШО		autopsy prior to completion of cause performed?  1 \( \sum Yes \) 2 \( \sum No \) 1 \( \sum Yes \) 2 \( \sum No \)	3 Of
ital		BeC	25. Was case referred to medical	26. Place of Death (Check only one)	
<u>f</u> <	g 5	10 E	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outp	atient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify)	
0		1.	27. Manner of Death 1 Natural 5 ☐ Pending (Month, Day Year) 28b. Tir	ne of 28c. Injury at 28d. Describe how injury occurred	
sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation	M 1 Yes 2 No	
Division	or Atl	Certification:	4 Homicide determined 28e. Place of Injury - At home, farr building, etc. (Specify)	n, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
L	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	Hos 1 24 h He Fur Hetely	edical		or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
	To the within 2 To the complet	W	29b. Signature and title of dentities	29c. License number 29d. Date signed (Month, Day, Year)	
			· ////~	DS4073 30 NOV Ob	
	4+1VA		30. Name and address of person who completed cause of death (Item 23a) (T	100, Print) 2CHMANS CAR NEWGSTLE DE 19720	
***	Sta Registr		31. Date filed (Month, Day Year) 1 2006 32. Refistrar's Signature	POP, Print) RCHMAUS CAR NEW CASTLE DE 19720	

State of Maryland / Department of Health and Mental Hydiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2006 11:50 a<sup>M</sup> DECEMBER James Leonard Russe11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's <u>Leonardtown</u> 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 10XM 2□F Yrs. Director 214-48-7387 83 Oct. 15, 1923 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funerai 22322 Cedar Street 20650 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. e filed within 72 hours after all Hygiene. I other than "nature!, or ite 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Š If Yes, Give Year or Dates: 3 Widowed 4 Divorced ed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) 8 Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I Pages 1 and 2 should be 2 Theodore Herbert Russell Agnes Violet Redmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if item 27 is eny Injury or other tra Mary Dryden / Sister 22322 Cedar Street, Leonardtown, Maryland 20650 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cr. 12-7-2006 Charlotte Hall, MD 21. Signature of Funeral Seguice Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** cose /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No this certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 No ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28d. Describe how injury occurred Medical Certification; 1 Natural 2 Accident Injury 5 Pending death investigation 1 ☐ Yes 2 ☐ No i Director: / 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral D Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM D BOYD II LEONARDTOWN MD 20650

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

DEC 0 6 2006

LEONARD

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39899 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** George Edward Rossback November 26. 2006 11:27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 6. Sex XX M 2□ F If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 17,1923 Birthplace (State or Foreign Country) **Funeral** 219-16-1086 83 July Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1285 Defense Highway 21054 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 MYes 2 □ No
If Yes, Give
Year or Dates: WWII 1 Never Married 2 X Married 1 ☐ Yes 2 💢 No White Specify ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry A.A.Co. Elementary/Secondary (0-12) College (1-4or 5+) Equipment Foreman Public Works 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Otto H. Rossback Olive V. Swink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naomi M. Rossback / Wife 1285 Defense Highway Gambrills, Maryland 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State re Crematory | 11/27/2006 | Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 5 ☐ Other (Specify) 4 Donation Baltimore Crematory 21. Signature of Fundral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MARION 600 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ő in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Settlo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. has been signed by page this certificate To the Hospital or Attending Physician: After within 24 hours arter commercial To the Funeral Director: A

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Cther: 1 Yes 2 ER/Outpatient Certification; To 2 No 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide 🚝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and lith of certifier 29c. License number 29d. Date signed (Month, Day, Year)

2108 (J. Dauh It w Clerk, Ms 2/6/9

Registrar DHMH 17 Rev 1/2001

State

200

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

VILL

8 2006

		_ rui	artment of Health and Mental	Hygiene	39900
		Registrar  1. Decedent's Name (First, Middle, Last)		of Death	, 0,,,00
Physici	an		Mon	th Day Year	
/Medic		Robert Leon Robins  4a. Facility Name (If not institution, give street and number)	Nove:	mber 18, 200	
Examin	er	Shady Grove Adventist Hospital	Rockville		
Euporol		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.   8, Date	of Birth 9. B	irthplace (State or Foreign
Funeral Director		219-26-1391 1⊠M 2□F 67 Yrs.	Months Days Hours Min. (Mon Jan.	th, Day, Year)	country) ryland
		Usual Residence of Decedent			
rylan	_	10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
e Ma	5	Maryland Montgomery Gaithers	sburg		1X Yes 2 □ No
ਜ਼ੈ ਜ਼ੈ ਜ਼ੈ or 24	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	Country?
eth w		202 Park Avenue #311	20877	United S	
er de	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et	or No- 14. Race - Arr	nerican Indian, nite, etc.
s aff	by F	1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1957-70	1 ☐ Yes 2X No Specify:	Specify:	White
hour	edt		dent's Usual Occupation	16b. Kind of Busines	
in 72	Completed	(Specify only highest grade completed) (Give	kind of work done during most of working DO NOT use retired)		nd Drug
with iene.	E	Elementary/Secondary (0-12) College (1-4or 5+) 4 Gra	ant Manager	Adminis	0
Hyge H	ø	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, A	Middle, Maiden Sumame)	
Agenta Menta Treed	To B	Leon Snow Robins	Rose Mora	n	
should be under		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rural Route I		Zip Code)
elth a		Brian Robins / Son 9605	Alter Court, Rockville	e, Maryland 2	0854
or other or		20a. Method of Disposition 20b. Place of Disposition cemetery, cre	osition (Name of Date matory or other place)	20c. Location - City of	or Town, State
Page Title	k	I Dunai 2 Cremation 3 Deminovarion State	oln Crematory 11/22/200	06 Brentwoo	d, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23a or 28a-f show amportant: or other traumatic avant. Ita Medical Eraminar must be colified at ance.		21 Signature of Funeral Service Licenses	2 Name and Address of Facility		
88558			mple Tribute Funeral a 040 Rockville Pike, Roc	and Cremation ckville, Mary	land 20852
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, of heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respira	tory arrest,	Approximate Interval Between
Pnysician		Immediate Case (Final disease or condition Metastatic fibros			Onset and Death 5 years
/Medical		resulting in death)  a	od Coma		J years
Examiner		Sequentially list conditions b.			
D =	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
acute ind trans	Examiner	that initiated events c.			
e be exe sicien a burial:	ũ	Due to (or as a consequence of):			
9 <u>a</u> E E	dlcal	d		····	
eath certific attending pl	Physiclan/Me	IF FEMALE:			1.,
ath cer attendin for use	lan/		Ectopic pregnancy	23d. Date of do	elivery Day Year
e a de di	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5	Other (specify)		
ires that the de signed by the a		Part II. Other significant conditions contributing to death but not resulting in the u	indertving cause given in Part I. 23e.	. Did tobacco use contribute	to the cause of death?
signe d be	d by	Sepsis		1 ☐ Yes 2 ☒ No 3 ☐ F	Probably 4 Unknown
w require been si should l	Completed		24-	14. On W	
hes hes	ם	Pneumonia	24a	Was an autopsy prior to death?	autopsy findings available completion of cause of
r: Tr				Yes 2⁄QXNo 1 ☐ Ye	es 2 No
STOIL OF VIKIN INC. Itanding Physician: The law leath. Iter: After this certificate hes b the funeral director, page 2 s	Be	25. Was case referred to medical examiner?	26. Place of Death (Check		
Phys ral di	- To	1 ☐ Yes 2 ☐ No	1 3 DOA 4 Nursing Home 5	Residence 6 Other (Sp cribe how injury occurred	ecify)
After fune	盲	1▲Natural 5 Pending (Month, Day Year) Injury	f 28c. Injury at 28d. Des Work?  M 1 ☐ Yes 2 ☐ No	onde now injury occurred	
tten deat ctor: y the	lca	3 Suicide 6 Could not be 280 Place of Injury At home form at		tion (Street and Number or F	Rural Route Number
after Dir.	Certification:	4 Homicide determined building, etc. (Specify)	City	or Town, State)	
spita ours nerai		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place, and due t	to the cause(s) and manner a	as stated.
To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the	time, date and place, and du	ue to the cause(s)
To th To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	nth, Day, Year)
		1 Hursen L SSFX	D43083	11/27/200	)6
10+1		30. Name and address of person who completed cause of death (Item 23a) (Type,		11/2//200	
		George A. Sotos, M.D. 9707 Medica	1 Center Drive #300, R	Rockville. MD	20850
Sta		Of Car Clad (March Con Vers)			
Regist	ar	MOV 2 9 2006 32. Hegistrar's Signature	parti		

			1 - For State Registrar	State	of Maryla		artmen <i>rtificati</i>			and M	lental		ene 0 0	6	39	901	
			1. Decedent's Name (First, Middle,	Last)							2. Date of	f Death			3. Time o	of Death	
н	Physici		Muriel Rosof	f Ral	oin						Nove		23, 20	Year 006	7:45	а м	
	/Medi Examir		4a. Facility Name (If not institution,	give street and nu	ımber)		4b. City,	Town, or	Location of	of Death			4c. County o		1		
			17 Hawthorn Cou	ırt			Ro	ckvi	11e				Montgomery				
	Funeral			. Sex	7. Age (In yrs	. last birthday)	If Under	1 Year	If Under		8. Date of	f Birth		9. Birthp	lace (State	or Foreign	
	Director		131-24-2004	1 ☐ M 2 🖾 F		73 Yrs.	Months	Days	Hours	Min.	Nov.	, Day, Y 25 •	1932	Ne	w Yor]	k	
	P .		Usual Residence of Decedent														
	show	_	10a. State 10b. County		10c. C	ity, Town or Lo	cation							1	Od. Inside C	•	
	Ba-f	cto		omery	]	Rockvil	le								1 (XYes	s 2 □ No	
	ith th	Directo	10e. Street and Number				10f. Zip	Code				10g	. Citizen of Wh	nat Cour	itry?		
	23a		17 Hawthorn Cou	rt			2	0850					United	1 St	ates		
	eme.	Funeral	11. Marital Status	12. Was Dec Armed F	cedent Ever in U orces?	J.S. 13. \	Was Deced	lent of Hi	spanic Orig	gin? (Spe	ecify Yes o	r No-	14. Race Black	- Americ White,			
S	or l		1 ☐ Never Married 2 ☒ Marrie	If Yes, G			1 □ Yes		Specify:				Specify:				
9500-61212	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Iteme 23a or 28a-f show ther then madical Examinat must be notified at	d by	3 Widowed 4 Divorced	Year or I	Dates:								Dpoony.	Whi	te		
ပ်	"nat	Completed	15. Decedent's (Specify only highest		)	16a. Deced	kind of wor	rk done d	urina most	of worki	ng	16	b. Kind of Bus	iness/In	dustry		
7	Po Po	E C	Elementary/Secondary (0-12)	College (	(1-4or 5+)		DO NOT us		,								
	e filed Il Hygie other		17. Father's Name (First, Middle, La			но	memak	er	18 Mothe	r's Name	/Eirot Mi	ddio Ma	Own Ho				
Ĕ	9 = 0 >	Be	Maurice Rosoff	,							, ,			,			
Maryland	should be nd Mental marked ( umatic ev	10	19a. Informant's Name/Relationship	(Type Print)		10h Mailin	a Addrasa	/Ctrant o			Rose		rg City or Town, S	4.4. 77.	0- 4-1		
2	as 1 and 2 should b of Health and Ment (frem 27 is marked r other treumatice		Robert Rabin/Hu				-										
	1 and Heali em 2		20a. Method of Disposition		20b.	Place of Dispo			urt,		CVIII. Oate		ary1and				
פֿ	T or Y		1 ☐ Burial 2 ☑ Cremation 3		State	cemetery, cren	natory or of	ther place	1				c. Location - C	ity of 10	wn, State		
saitimore,	it. Pag rdment rdant: njury o		4 Donation 5 Other (Spe		Ft.	Linco					/2006	5 ]	Brentwo	od,	Mary1	and	
a a	permit. Pages Depertment of I Important: If tte eny Injury or of		21. Signature of Funeral Service Li	ensee		5 <u>i</u> 1	. Name an pple	a Addres Trib	ute F	uner	al ar	nd C	rematic le, Mar	n Ce	enter		
		$\vdash$	220 Port Francisco discoso et a	maliantiana that		104	40 Ro	ckvi	lle P	ike,	Rocl	cvil	le, Mar	y1aı			
			23a. Part / Enter the disease, of coshock or heart failure. List or	lly one cause on	each line.	th. Do not ente	er the mode	e or ayıng	, such as	cardiac o	r respirato	ry arrest			Approxima Interval Be Onset and	lween Death	
}	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a. Meta	static	lung ca	ancer								Month		
	Examiner			Due to	(or as a conse	quence of):											
		-	Sequentially list conditions, farry, leading to immediate cause. Enter Underlying	b. Thus to	(or as a consec	austron after											
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	54010	100 46 4 60 1641	querior ory.											
•	xecu and	xar	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):								-			
0/0	icate be executed physician and s the burial-transit		1														
20	icate phys	dlcal		d										+			
	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	IF FEMALE:	23c. If yes, ou	tcome of pregn	ancv							and Date	at dati			
Ž D	death e atten	clar	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta nant at time of c	al death 3 🗆	Ectopic pre						23d. Date Month		-	Year	
j	y the d	ysl	1 □ Yes 2 🖾 No 9 □ Unknown	9□ Unkr			Onion (ape	July/				_					
ŗ	requires that the een signed by th hould be detache	d	Part II. Other significant condition	s contributing to d	leath but not res	sulting in the un	iderlying ca	ause give	n in Part I.		23e. C	id tobac	co use contrib	ute to th	e cause of o	death?	
spiosa	urres sign ld be	Completed by	Mitral stenosis								1	☐ Yes	2 □ No 3	☐ Prob	abiy 4 ⊠i	Unknown	
Š	w req beer shou	lete									04- 1		245.346		100000		
ย	et co	m d									a	Vas an utopsy erformed	24D. We	ore autop or to con ath?	osy findings apletion of c	available ause of	
	n: T/ ficete r. pa											s 2 🛭		Yes	2 No		
=	Physician: The to this certificete he ral director, page 2	Be C	25. Was case referred to medical examiner?	Hospital:				Othe	_		Check of			_		_	
5	Phys r this ral dir	5	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date		ER/Outpatient 28b. Time of		^	4 🗀 1901				e 6 □Other		)		
5	ding h. Afte fune	ţ	1 ⊠Natural 5 ☐ Pending	(Mon	nth, Day Year)	Injury	м	Bc. Injury Work	? es 2□N		.ou. Desci	DO HOW	injury occurred	•			
INISIOI	deat deat ctor: y the	Certification;	3 ☐ Suicide 6 ☐ Could no	be Jac Bloom	e of Injury - At h	ome farm stre					Rf Locatio	n /Stree	t and Number	or Rum	Poute Num	her	
2	after Dire	ert	4 ☐ Homicide determine	build	ing, etc. (Speci	fy)	ot, lactory,	Onico		-		Town, S		or riural	HOUSE / VIII	1067,	
_	To the Hospital or Attending Ph within 24 hours atten death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying	Physician: To the	e best of my kno	owledge death	occurred a	at the time	a date and	i place a	ind due to	the caus	a(c) and ma	of an ch	ated		
	• Ho 24 h • Fui etely	Medical	one) Z Medical Ex	aminer: Un the t	asis of examination stated.	ation and/or inv	estigation,	in my op	inion, death	h occurre	d at the ti	ne, date	and place, and	d due to	the cause(s	i)	
	within of the complete of the	Me	29b. Signature and title of certifier	( )			29c.	License	number			29d.	Date signed (	Month, L	Day, Year)		
	->-0		) Xt	/ ) -	long 1			D201	48			1				6	
	8	11	30. Name and address of person wh	o completed care	se of death (Ite	n 23a) (Type 1	1	נטבעו				I IN	lovembe:	L 2/	, 200	U	
	U		Steven H. Doli			11 Russ		170	10 0	oi+h	orah	<b>*</b> C	Mo1	م نہ	0070		
	Sta	te	31. Date filed (Month, Day, Year)		istrar's Signa	ature			وعد	all!	EISDU	r.R.	<u>тагута:</u>	na Z	08/9		
	Registr		NUV 2 9	2006	Mark and	K A	2346										

			1 - For State Registrar	State of	Marylan		rtment of H	lealth and M	_	211	กร	39902
			1. Decedent's Name (First, Middle, Las	t)				Dodin	2. Date of De	Reg. No		3. Time of Death
	Physic /Medi		Warren Calvin R	oberts					Month Decemb	er 4, 20	Year 106	14:55 P.M
	Exami		4a. Facility Name (If not institution, give	street and numb	ber)		4b. City, Town, o	or Location of Death		4c. County		
			Harford Memoria	l Hospit	tal		Havre	de Grace		Har	ford	
	Funeral		Social Security Number     6. Security Number	9x 7 2XM 2□F	. Age (In yrs.		Il Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 9. 8			place (State or Foreign ntry)
	Director		225-24-4857 Usual Residence of Decedent	ZLIVI ZLI F	85	Yrs.			1/4/19	21	Vir	gínia
	land		10a. State 10b. County		10c. Cit	y, Town or Loc	cation					10d. Inside City Limits
	Mary -1 sh	ğ	MD Harfor	ď	Ak	erdeen						1 <b>X</b> Yes 2 □ No
	1036  ours after deeth with the Maryland rat', or Items 23e or 28e-1 show Examirer must be notilised at	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Cou	ntry?
	h with		611 Westwood Dr	٠.			2100	11		U.S		,
	deeti ms 2	Funerai	11. Marital Status	12. Was Deced		S. 13. V		Hispanic Origin? (Spi an, Mexican, Puerto	ecify Yes or No		e · Americ	can Indian,
	after or Its	Ī	1 ☐ Nøver Married 2 ☐ Married	Armed Ford 1 ☐ Yes 2 If Yes, Give	No		_		Rican, etc.)		k, White,	
	DO3	d by	3 XWidowed 4 □ Divorced	Year or Dat	<i>e</i> s:	'	□Yes 2⊠No	Specify:		Specify	. Whi	ite
	1215-0036 within 72 hours after dee ane. than "natural", or Items than Maddical Examinarm	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Deced (Give I	ent's Usual Occup and of work done	oation during most of work d)	ing	16b. Kind of Bu	siness/In	dustry
	withigh 12	Ę.	Elementary/Secondary (0-12)	College (1-4	or 5+)		worker/s	•		Manufa	-c+111	cina
	Thyga A		17. Father's Name (First, Middle, Last)			preer	MOLVET\ 2	18. Mother's Name	e (First, Middle,			-1119
	Maryland 21215-0036 at 2 should be filed within 72 hours at the and Mental Hygiene. To is marked other than "naturel", or 77 is marked other than "naturel", or treumatic event, the Medical Extern	To Be	Charles Roberts						e Sulli		-/	
0	should Munder	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailing	Address (Street	and Number or Rura			State, Zir	Code)
	md 2 aith a stre		Joyce F. Robert	s (Daugh	nter)	622	Westwoo	d Dr. A	berdeen	, Maryla	and	21001
5	of He of He		20a. Method of Disposition			lace of Dispos	ition (Name of atory or other place		Date	20c. Location -		own, State
5	Page Page nent: ant: H		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		a:0   _	`	Cemetery	· 1	/06	Baltimor	æ, M	Maryland
7	Baltimore, Maryland 21215-0 permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturenty or other treumatic event, the Medical and.		21. Signature of Funeral Service Licens	500		22.	Name and Addre	ess of Facility	] [[	- 70 7		_
	00 897		BUSKING	noll	ngle	De A	berdeen,	argo fune Maryland	21001	-3399 <sup>A</sup> •		
			23a. Part1. Enter the disease, or composhock, or heart failure. List only of	lications that cau one cause on eac	used)the death ch line.	n. Do not ente	r the mode of dyin	ng, such as codiac o	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a	C	andi	m	noelly				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):	)	1				
9	- Adminic.	۰	Sequentially list conditions,	b. — Due to (or							_	
0	T Ded is	in in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a consequ	Jence or):						
7	8760, Cate be executed cate be executed chysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or	as a consequ	uence of):					-	
12	8760, cate be ex physicien the buria	dicai		d								
,		. •		d								
_	N Ceir Indir	by Physician/M	23b. Was deceder pregnant	23c. If yes, outco	me of pregna					23d. Date	of delive	эгу
	O. B.	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of de		Ectopic pregnancy Other <i>(specify)</i>	·		Mor	th	Day Year
9	P.O.	h	9 Unknown									
	S, F	þ	Part II. Other significant conditions co	ntributing to deal	th but not resu	ulting in the un	derlying cause give	en in Part I.				ne cause of death?
3	Cord  * requir  been si  should	ted							1 🗆 Y	es 2□No	3 🗌 Prob	ably 4 Dunknown
-	Division of Vital Records, or or Attanding Physician: The law requires tales death.  Director: After this cartificate has been signed in by the funeral director, page 2 should be	Completed							24a. Was a autop	an 24b. W	fere autorior to cor	psy lindings available mpletion of cause of
5	The I	ပိ							perfor 1 ☐ Yes	mea? 🖊 a	eath? □ Yes	
1	f Vital F yeiclan: Th is certificete director, pag	Be	25. Was case referred to medical axaminer?	Hospital:			Oth	26. Place of Death				
D.	Phys rathis	. To	1 ☐ Yes 2 12 No  27. Manner of Death	1 Mainb		ER/Outpatient 28b. Time of	3□ DOA Oth	4   Italishig Hol		ence 6 Othe		1)
Rober	VISION Of VITAI Attending Physician: r death. ector: After this certifice by the funeral director, i	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month,	Day Year)	Injury	28c. Injun Work	k? Yes 2 □ No	zod. Describe in	ow injury occurre	ď	
CC .	Attend r death octor: /	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of	Injury - At ho	me, farm, stre	et, lactory, office		281. Location (S	treet and Numbe	r or Rura	I Route Number
i	d in the	Certification;	4 ☐ Homicide determined	building	, etc. (Specify	)	•		City or Tow	n, State)		,
	ospit hour uners		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the be	est of my know	wledge, death	occurred at the tim	ne, date and place, a pinion, death occurre	and due to the c	ause(s) and mar	iner as st	ated.
	DIVISIO To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fu	fedical	one,	and manne	r stated.				ed at the time, d	late and place, a	nd due to	tha cause(s)
	or with con	Σ	29b. Signature and title ol certifier	100		MI	29c. License	0637	20 2	29d. Date signed	(Month, I	Day, Year)
							1)(	5000		121	7	(000
	10		30. Name and address of person who c	ompleted cause	O.CV	23a) (Type, P	rint) GAG	OICE	In IS	KAR	15	Dolali
	Sta	ate	31. Date filed:(Month, Day, Year)		istrar's Signat	ure	10778	CHNE	114, 15	CLITIA	M	V C/0/7
	Regist		DEC 1 3 2006	A COL	J J.S.	P. S. D. S. O. S.						

			1 - For State of Maryland / I	Department of H			ene 2006	39903
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici /Medi		Jane M. Scalzo			November	23, 2006	8:30a <sup>M</sup>
	Examir	ner	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or	r Location of Death		4c. County of Death	
			11127 Old Worton Rd.	Worton			Kent	
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 1 F 7. Age (In yrs. last bit 74	rthday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Cour	
			Usual Residence of Decedent			September	10,1932	PA
	how		10a. State 10b. County 10c. City, Tow	n or Location			1	0d. Inside City Limits
	e Ma	cto	MD Kent Wor	ton				1 <b>y</b> Yes 2 ☐ No
	ith th	Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of What Cour	ntry?
	s 23s	ra	11127 Old Worton Rd.	21678			U.S.A.	
	ter de	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Never Married 2 ★ Married  1 ☐ Yes 2★ No	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
936	urs af	by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2√2 No	Specify:		Specify: W	hite
ŏ	within 72 hours after deeth with the Maryland ene. than "natural", or items 23e or 28e-f ahow i.e Medical Examiner must be notified at	ted	15. Decedent's Education 16a.	Decedent's Usual Occup	ation	16	6b. Kind of Business/Inc	dustry
21	thin 7	ple.	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	during most of work ii)	ing		
2	ed wi	Completed	12 –	Housewife	<u> </u>		Househ	old
and	be fill bd otl	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Ma	aiden Sumame)	
ž	hould d Mer marks marks	ဥ	Edward Price  19a. Informant's Name/Relationship (Type, Print) 19b			Andrews		
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after deeth with the Maryian it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f ahow or other traumatic avent, If a Wedical Engminer must be notified at			. Mailing Address (Street a				(Code)
	Heal Heal tem 2	-	20a. Method of Disposition 20b. Place of	O Redfield D  f Disposition (Name of			21921 Oc. Location - City or To	own. State
ομ	ages ant of nt: if i		I C Dunai 2 Carination 3 C namoval nom 3tate	ry, crematory or other plac Ferris Inc.	Novemb	20	West Chest	
Baltimore,	permit. Pages 1 an Department of Heali Important: If Item 2 any injury or other once.		21. Signature at Eulergi Service Licensee	22. Name and Addres	200		West Chest	er, pA
ä	Depa Impo any i		23a. Part1. Enter the disease, or complications that caused the death. Do	Andrew G.				
8760,	Physician /Medical Examiner bubsicien and streep physicien and the partial-itansit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the cause).  Due to (or as a consequence of the cause).  Due to (or as a consequence of the cause).	of):	Lucil	Sele	101	Onset and Death
.O. Box 6	The law requires that the death certificate be executed ate hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregorant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delive Month	ry Day Year
o,	ss that gned b	by PI	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause give	an in Part I.	23e. Did toba	coo use contribute to th	e cause of death?
ğ	w require been si should b	ted	Chranic Obstructe Pu	many!	June	1 ☐ Yes	2 No 3 Prob	ably 4 □Unknown
Records,	he taw r hes be ge 2 sh	Completed				24a. Was an	24b. Were autor	osy findings available
_	The page	5				autopsy performe 1 Yes 2		2 No
Vita V	icien: ertific ector,	Be	25. Was cash referred to medical examiner?			(Check only one)		
of	Physi this o	5	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou		4   Nursing Hor		ce 6 □Other (Specify	)
o	ding h. After funer	L o	1 Natural 5 Pending (Month, Day Year) In	Time of 28c. Injury Work  M 1 □ Y	rat ⟨? Yes 2 □ No	28d. Describe how	injury occurred	
Division of Vital	To the Hospital or Attending Physicien: The twithing Venus after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fair building, etc. (Specify)			28f. Location (Stree City or Town, S	et and Number or Rural State)	l Route Number,
	To the Hospita within 24 hours To the Funeral completely filled	Medical (	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge 2. Medical Examiner: On the basis of examination and manner stated.	, death occurred at the tim	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as sta and place, and due to	ated, the cause(s)
	Vith Com	Σ	29b. Signature and title of certifier	29c. License	number	29d	. Date signed (Month, L	Day, Year)
	h. 1				51786	8	11-38-CL	ė.
	6		30. Name and address of person who completed use of death (Item 23a) (	Type Print)	Obil	L 11	11-38-CL D 21620	
	Sta	to	Andrew S. Ferguson HD 120 Special Date filed (Month, Day, Year) 32. Registrar's Signature	a kn pladp	Chester	Jan M	1) 911090	
11	Registr	_	NOV 3 0 2006	we				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mildred Jean Smith December 01, 2006 3:45 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cumberland Nursing Home Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Hours 1 M 2 7 F Maryland 213-12-9034 81 Director May 24, 1925 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Allegany Cumberland Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 512 Winifred Road 21502 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other than "naturel", or fler any injury or other traumatic event. ☐Yes 2X No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. þ Specify Year or Dates: 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Textile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ္ Robert Izat Marian Cuthbertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Mundeno - Nephew 13800 Briarwood Drive SW, Cumberland, Maryland, 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State December Frostburg Memorial Park ^ 4 Donation 5 ☐ Other (Specify) 06, 2006 Frostburg, Maryland 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 21. Signature of Funeral Service Licensee 2 8 East Main Street, Lonaconing, MD 21539 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Athero scleroti eun) /Medical Examiner Sequentially list conditions, y cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funerel Direct 4 Homicide 1 Contifying Physician: To the Dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

VikramadityA Tooner MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature 5 Registrar

30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

		-	For State Registrar		State	of Marylan	-	artmen <i>rtificat</i>			Mental F	lygiene Reg. No.	006	39905
	Physicia	-20	1. Decedent's Name (	First, Middle,	last)	Sme	avn	100			2. Date of Month	Day	Year O	3. Time of Death
	/Medic Examin		4a. Facility Name (If n	ot institution, g					Town, or	Location of Dea			County of Death	
			3740 Frien						end:	sville.			arret	
	Funeral Director		<ol> <li>Social Security Num</li> <li>220–28–974</li> </ol>		.Sex 1 <b>X</b> M 2 □ F	7. Age (In yrs.	last birthday) 5 Yrs.	If Under Months	Days	If Under 24 Hrs Hours Min		7, YTG		place (State or Foreign Intry) and
	and ow		Usual Residence of D	ecedent 0b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
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	th the	Director	10e. Street and Numb	er				10f. Zip	Code			10g. Citiz	en of What Cou	untry?
	ath wil	rai	3740 Frien	dsvill					531			USA		
36	in 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show refeal Examiner must be notified at	by Funerai	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>3 ☐ Widowed 4</li></ul>		Armed F	cedent Ever in U Forces? 2 □ No Sive Dates: 1951		Was Dece If Yes, spe 1 Yes	city Cubar	spanic Origin? (S n, Mexican, Puer Specify:	opecify Yes or to Rican, etc.)		4. Race - Amer Black, White Specify: W	
9500-61212	2 hou		1:	5. Decedent's	Education		16a. Dece	ident's Usu	al Occupa	ition	orking	16b. Kir	d of Business/I	ndustry
22	within 72 ene. then "nat	Completed	(Specify Elementary/Second		grade completed College	(1-4or 5+)	life.	DO NOT u	se retired)	uring most of wo	nking	Fire	Brick	
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<u>Z</u>	Shou nd N	ပ	19a. Informant's Nam		o (Type, Prin <b>§</b> 11	earman	19b. Maili	ing Address				mber, City or	Town, State, Z	ip Code) 21531
	2 6 2 6		Matilda M.	(Prink	ey/Wife		1			lle-Addi				
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Baltimore,	tment of tant: If it tant: If it		4 ☐Donation 5	Other (Spe	ecify)		dison			1			son, PA	
Ra	permit. Page Department of Important: If any injury or once.		21. Signature of Fune	aral Service Li	Jel.	mae				s of Facility Ne 75, Gran			21536	P.A.
3	Physician /Medical	2 (1	23a. Part 1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)		_ a L	caused the deat each line.	Ca			g, such as cardia		y arrest,	tey!	Approximate Interval Between Onset and Death
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	ed sslt	iner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in that initiated events	rediate ving iurv	Due to	o (or as a consec	quence of):							
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Division of	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completaly filled in by the funeral director, page	Certification:	3 Suicide 4 Homicide	6 Could no determin	ot be 28e. Pla	ce of Injury - At h Iding, etc. (Speci		treet, factor	y, office		28f. Locatio City or	n (Street and Town, State)	d Number or Ru	ral Route Number,
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			30. Name and add	s of person w	no completed on	use of death (Ite	m 23a) (Type	Print)	M	1611	1/1	λ.	0.1	10.10.00
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			For State Registrar	State of Maryland / Dep.	artment of Health and rtificate of Death		ene 006	39906
	*		1. Decedent's Name (First, Middle, L	ast)		2. Date of Death		3. Time of Death
	Physici /Medio		Virginia	Aline	Simms	Novembe	r 22,06	3:23 P M
	Examir		4a. Facility Name (If not institution, g		4b. City, Town, or Location of Deat	h	4c. County of Dea	
		The c	4703 Beauford	Road	Suitland		Prince (	Georges
	Funeral Director		5. Social Security Number 6. 216-22-0722 Usual Residence of Decedent	Sex 1 □ M 2 🖔 F  7. Age (In yrs. last birthday)  76  Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		1.929 9 Bi r29 Mai	rthplace (State or Foreign ountry) ryland
	land ow		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
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	r 28s	Directo	10e. Street and Number	e seorges burerant	10f. Zip Code	100	. Citizen of What C	ountry?
	h wit	a D	4703 Beauford	Road	20746		USA	
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ກັ	Health tem 27 other to	1 8	20a. Method of Disposition	20b. Place of Dispo	osition (Name of	ole Hill	Marylan c. Location - City or	Town, State
2	Pages nent of I int: if it		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	Hemoval from State	matory or other place)	10/000		_
pailimore,	교 된 본 분 .		21. Signature of Funeral Service Lic	SHITOH De	ethel AME 11/3 2. Name and Address of Facility A	0/2006 E	Brandywi	ne,Marylan
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	Diam'r a		shock, or heart failure. List on Immediate Cause (Final					Interval Between Onset and Death
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<b>5</b>	ding Ph After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 28b. Time o (Month, Day Year) Injury		28d. Describe how		
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<u> </u>	l or Attendation after death Director:	ŧ	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
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	To the Ho within 24 h To the Fu completely	Med	one) 29b. Signature and title of certifies	and manner stated.	29c. License number			
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	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 1	2006 Mariae A	heets,			
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DHMH 17 Rev 1/2001

		-	For State Registrar	State of	f Marylan		ertment of		nd Mental Hy	giene 0	16 39907
			Decedent's Name (First, Middle,	Last)					2. Date of De	ath	3. Time of Death
	Physicia		Robert N	luscoe	Sar	ns			Decemb		06 3:40 a M
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town,	or Location of I		4c. County of	
	LAGITIII	•	Charlotte Hall	l Veterans	s Home		Char1	otte Ha	11	St. I	Mary's
	Funeral		5. Social Security Number		7. Age (In yrs. I	ast birthday)	If Under 1 Yea Months Days	r If Under 24	Min. (Month, Da	th v. Year)	Birthplace (State or Foreign Country)
	Director		578-24-9292	1 <b>X</b> ∑XM 2□F	80	Yrs.	Wiorius Day.	710013	Dec. 2	7, 1925 I	North Carolina
	p >		Usual Residence of Decedent  10a. State 10b. County		10c Cib	, Town or Lo	cation				10d. fnside City Limits
	sho	5									1 ☐ Yes 2X No
	Ne M	Directo	Maryland St. 1  10e. Street and Number	Mary's	Me	echani	csville 10f. Zip Code	-		10g. Citizen of W	/hat Country?
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	eath	Funeral	11. Marital Status		edent Ever in U.	S. 13. V			n? (Specify Yes or No		- American Indian,
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215-0036	d within 72 hours after death with the Maryland siener then "naturel", or itema 23s or 28s-f show the Medical Examinar must be notified at	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	re ates:		1⊡Yes 2√CXN	Specify:		Specify:	White
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Division of		cat	2 Accident investig	not be 200 Place	of Injury - At h	ome, farm, st	reet, factory, offic			Street and Number	er or Rural Route Number,
<u>≥</u>	efter Direction by	ertification;	4 Homicide determ		ing, etc. (Specif		out, ractory, only			wn, State)	
	To the Hospital or Attenwithin 24 hours efter deation to the Funeral Director: completely filled in by the	a C							place, and due to the		
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VV	To ti Vithi Comp	Σ	29b. Signature and title of certifier	21			29c. Lice	nse number	2.0	29d. Date signed	d (Month, Day, Year)
}			Para	10	am	wo	1	<i>1</i> 450	92	121	1106.
			30. Name and address of person	who completed caus	se of death (Iter	n 23a) (Type,	Print)	- 7	)	- 1	TID TO
			31. Date filed (Month, Day, Year)	al K	d S	we	# 40	) > T	rince	rea	VICE 2061
	Sta Registi		DEC n & 2001	6 6	Registrar's Signa	A D	_				,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** 2006 6:00 <u>Grace Merryman Sheaffer</u> December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Leonardtown, Maryland St. Mary's Nursing Center
5. Social Security Number 6. Sex 7 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F June 27 1922 Washington, DC Director 577-28-6537 84 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 □Yes 2X No Maryland
10e. Street and I Leonardtown St. Mary's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with items 23a 20650 U.S.A. Andrews Church Road Funeral 42510 St. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 'n, 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Post Office Postmaster 7 Is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl A. Merryman Grace Glick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42510 St. Andrews Church Road, Leonardtown, MD 20650 item 27 l Greg Copado/ Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. George United
Methodist Cemetery 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or o
once. 1 Bunal 2 □ Cremation 3 □ Removal from State 2006 St. George Island, MD 4 ☐ Donation 5 ☐ Other (Specify) 8, Dec. 22. Name and Address of Facility e of Juneral Service 22955 Hollywood Rd, Leonardtown, MD 20650 Brinsfield M00052 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LYRS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 Physician/Medical þ

Completed Be Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pic pregnancy er (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underly	ving cause given in Part I.	23e. Did tobacco  1  Yes 2  24a. Was an autopsy performed? 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical		26. Place of Deat	h (Check only one)	
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 42 Nursing Ho	ome 5 Residence	6 □Other (Specify)
27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how inju	
3 Suicide 6 Could not b 4 Homicide determined		actory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Example 1 Medical Example	nysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investige and manner stated.	urred at the time, date and place, gation, in my opinion, death occur	and due to the cause( rred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Day, Year)

State Registrar

Medical

William D. Boyd II, M.D., 25365 Point Lookout Road, Leonardtown, MD 20650

32. Registrar's Signature 31. Date filed (Month, Day, Year) DEC 0 6 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 hours a

4-06.

			1 - For State Registrar	State of Mar		artment of H rtificate of I			giene Reg. Ng. ()	06	39909
	Sig. 9		Decedent's Name (First, Middle, Last	st)				2. Date of De	ath		3. Time of Death
3	Physici /Medic		Mary Ja	ne Scott				Month Novembe	r 22	2006	7:05 P
1	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Death		4c. Cour	nty of Death	
344			7810 Fiske A		4 IA 5-14 4 1		lenarden				George's
	Funeral Director		5. Social Security Number 6. S	ex / Age ( ☐M 2【X】F	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)		place (State or Foreigntry)
			251-05-4128 Usual Residence of Decedent		92			June 26	, 1914	Sout	h Carolin
	ylanc how		10a. State 10b. County	1	Oc. City, Town or Lo	cation					10d. Inside City Limits
	Ba-f-	cto	Maryland Prince	George's		(	Glenarden				1 XYes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Cou	ntry?
	e 23s		7810 Fiske				20706				States
250	Awithin 72 hours after death with the Maryland sien. Jien. Then "netural; or Iteme 23s or 28s-f ehow Its Madical Examination rolling at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 □ Yes 2🌠 No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Spec		etc.
5	2 hou	ted	15. Decedent's Ed		16a. Deced	ient's Usual Occup	ation		16b. Kind of		Black Industry
7	within 7 ene. then "n re Mad	Completed	(Specify only highest gra	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of worki	ng			
Maryiand 21215-0036	filed with Hygiene. ther the	Con	5th			Maio	i		I	rivat	:e
	be d all	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Suma	ame)	
2	2 should be and Mental le marked aumatic ev	은	Lee Owens	T 0 1 1					Boatwri		
2	d 2 si th and 7 le r traur		19a. Informant's Name/Relationship (			50 Ed. 50	and Number or Rura		-	100 0	Code)
	ges 1 and 2 should t of Health and Mer If Item 27 le marke or othar traumatic		Dorothy E. Jone 20a. Method of Disposition	s/Daughter	20b. Place of Dispo	sition (Name of		Glenar	den MI 20c. Location	) 207	
ballinore,	Pages nent of I ant: If its ary or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific			natory or other plac	i	Janes			2000
	그 된 변경 .		21. Signature of Funeral Service Licen			OIN Cemet  . Name and Addres	ery 12/2			twood	7.
Ď	Depa Depa Impo eny it		I ohy T. <	Lewar.		4001 F	Benning Ro	Stewart			
. 93	-4%		23a. Part1. Errer the disease, or com- shock, of heart failure. List only		e death. Do not ent					DC 2	Approximate Interval Between
	Physician		Immediate Cayse (Final disease or condition		re to thr	ivo					Onset and Death
	/Medical		resulting in death)	Due to (or as a		LVE					Months
	Examiner	V .	Sequentially list conditions,		e dementia	a					Years
	pe #s	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of).						
	and and II-tran	Examin	that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):						
00/00	ficate be executed physician and s the burial-transit	alE		.,							
		edical		. G							
7.0. DOX	that the death certified by the attending detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tin	Fetal death 3	Ectopic pregnancy Other (specify)				ate of deliver	ery Day Year
	res that the signed by the be detache		Part II. Other significant conditions of	ontributing to death but	not resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use co	ntribute to t	he cause of death?
2	law requires as been sign 2 should be	ed by	Coror	ary Artery	Disease,	Hyperten	sion	1 🗆 ነ	es X No	3 🗆 Prob	pably 4 Unknown
3	s been si	Completed						24a. Was		. Were auto	opsy findings available
ב	0 - 6	E o							rmed?	prior to co death? 1 \( \text{Yes}	mpletion of cause of
	ysician: Th	Be C	25. Was case referred to medical				26. Place of Death		2 to No	1 1 103	2   140
5	Z	ToE	examiner? 1 ☐ Yes 2 ☆ No	Hospital: 1   Inpatient	2 ER/Outpatien	t 3 DOA Othe	er: 4 🗌 Nursing Hor	ne 5 🗓 Resid	dence 6 □0	ther (Specif	(y)
			27. Manner of Death  1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	28b. Time of Injury	28c. Injury Work	at (?	28d. Describe t	now injury occu	urred	
2	Attending r death. sctor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				
=	or Atten after deatl Director: I in by the	Certification;	4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, stre 'Specify)	eet, factory, office	1	28f. Location (3 City or Tox		nber or Rura	al Route Number,
	Hospital	dlcal Ce	29a. Certifier 1 Certifying Ph	ysician: To the best of a niner: On the basis of ea and manner state	amination and/or inv	occurred at the time	ne, date and place, a pinion, death occurre	and due to the o	cause(s) and n	nanner as s	tated. o the cause(s)
	To the within 2 To the complete	Med	29b. Signature and title of certifier	A A		29c. License	number		29d. Date sign	ed (Month,	Day, Year)
	->-0		1 Leta /	eller-		1	D22780		Novemi	her 25	7, 2006
D	(2)		30. Name and address of rson who	completed cause of dear	th (Item 23a) (Type,		J=1,00		110 v emi	UC1 4/	, 2000
1			Peter M. Schiss	ler, M.D.	7500 Gree		ter Dr.,	#430, G	reenbe	lt, MI	20770
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 8 2006	32. Registrar's	Signature						

		For State Registrar  1. Decedent's Name (First, Middle,					of Health and of Death		Reg. No	$Z \coprod$	U 6	3 9 9 1 (
ysicia Medic			ed Shannon					November 12 Date of Da	Da	9	2006	10:35P
camin		4a. Facility Name (If not institution,	give street and number)	)		4b. City, T	own, or Location of Dea					
			sing & Reha			If I be when d	Clinton			Prince George's		
eral ector			6. Sex 7. Ag		ast birthday)	If Under 1 Months	Year If Under 24 Hrs Days Hours Min	. (Month, Da	y, Year			place (State or Forei
		578-54-8296 Usuel Residence of Decedent		(	66 113.			Oct. 1:	5, 1	940	Wa	sh., DC
any injury or other treumatic event, the Madical Exeminer must be notified at once.		10a. State 10b. County		10c. City	, Town or Loc	ation						10d. Inside City Limi
office	Director	DC					Washing	ton				1 XYes 2 N
200	2	10e, Street and Number	1 0	an		10f. Zip (			10g. C		What Cou	
THE STREET	Funeral	1. Marital Status	avannah St.,	Ever in U.	S. 13, W	Vas Decede	20032 int of Hispanic Origin? (	Specify Yes or No				States
	Fur	1 Never Married 2 Marrie	Armed Forces		lf lf	Yes, specif	y Cuban, Mexican, Puer	rto Rican, etc.)	}		ck, White	frican
	d by	3 Widowed 4 Divorced	Year or Dates:			☐Yes 2	No Specify:			Specil	y: A	merican
	Completed	15. Decedent' (Specify only highest			16a. Decede	ent's Usual kind of work O NOT use	done during most of wo	orking	16b. F	(ind of B	Business/Ir	ndustry
	dwo	Elementary/Secondary (0-12) 12th	College (1-4or	5+)	me. D						Corro	
	a	17. Father's Name (First, Middle, L	ast)		L	Hous	sekeeping 18. Mother's Na	me (First, Middle,	Maide	Sumai		rnment
	To B	Prince	Albert Sha	annon				Edna	a Ma	e Dy	yson	
		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailing	g Address (	Street and Number or R	ural Route Numbe	er, City	or Town	, State, Zi	p Code)
		James Edward	l Stewart/So		1	323 E	Surlington I	Drive, Oc				
		20a. Method of Disposition 1 X Burial 2 ☐ Cremation			lace of Dispos emetery, crem	atory or oth	er place)	Date	20c. L	ocation	- City or T	own, State
.		4 □ Donation 5 □ Other (Sp 21. Signature of Fineral Service L		Han			al Park 11, Address of Facility					r, MD
once		Signature of American Service E	Staran t	TI	22.			Stewart				
		23a. Part1. Enter the disease, or o	complications that cause	d the death	Do not ente		01 Benning of dying, such as cardia			Π.,	DC 2	Approximate
		shock or heart failure. List of Immediate Cause (Final	only one cause on each I									Interval Between Onset and Death
		disease or condition resulting in death)	Due to (or as	a consequ	uence of):	£ 1						
ı		Sequentially list conditions.			right	ما ت	29					
1	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to (or as		j mell	itus						
	Examiner	that initiated events resulting in death) Last	c. Due to (or as									
	<u>a</u>			·								
	edic		d									
	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pre	gnanew.			23d. Da	ate of deliv	rery
	sicis	in the past 12 months?	4□Pregnant a			Other (spe				Mo	onth	Day Year
		9 ☐ Unknown  Part II. Other significant condition		but set see	diam's the sec	4-43	on the Control	an Dida			1 /h	
	1 by						use given in Part I.		res 2	1		the cause of death?  bably 4   Unknow
	ete		entis.	14.20	tenler	2		24a. Was				
	Completed	uen	enter.	17 /10				autop	med?		prior to co death?	opsy findings availat empletion of cause o
	0	25. Was case referred to medical					26 Place of De	1 ☐ Yes eath (Check only o	2 N	)	1 🗆 Yes	2 No
	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 🗆	ER/Outpatient	3 DOA	0.1	Home 5 ☐ Resid		6 🗆 Otl	her (Speci	fv)
		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time of Injury	28	c. Injury at Work?	28d. Describe				**
	Certification:	2 Accident investig	ation			М	1 ☐ Yes 2 ☐ No					
	Ē	3 Suicide 6 Could no 4 Homicide determin	had   286. Place of in	jury - At ho tc. <i>(Specif</i> y	me, farm, stre /)	et, factory,	office	28f. Location (: City or Tox			ber or Run	al Route Number.
		29a. Certifier 1 ☐ Certifying	Physician: To the hest	of my know	wledge death	accuract a	the time date and place	a and due to the	201122	\		
	Medical	(Check only 2 Medical E	Physician: To the best examiner: On the basis of and manner s	of examinat	tion and/or invi	estigation, i	n my opinion, death occ	urred at the time,	date an	d place,	anner as s and due t	to the cause(s)
	Me	29b. Signature and title of certifier				1 0	License number					Day, Year)
		Mens an	160	TUD	)	1	002270	8	1	-	20-	06
		,				1						
)		30. Name and address of person viller Sair d  31. Date filed (Month, Day, Year)  NOV 28 200	who completed cause of	death (Item	23a) (Type, P	rint)	A./	-707				

DHMH 17 Rev 1/2001

Am	ended	#	State of Maryland / De State of Maryland / De Registrar#2 Per Phy, gc, 12/0606	partment of Health and ertificate of Death		ene 006	39911	
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death	
	Physici /Medio		MIKE NOLAN SLOAN		NOVEMBER	1	11:00AM	
1	Examir	er	4a. Facility Name (If not institution, give street and number) 4311 CRELIN PLACE	4b. City, Town, or Location of Dea	ith	4c. County of Death PRINCE GE	EORGES	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda			h 9 Birthplace (State or Foreign		
	Director		431 58 5994	Mortuis Days Tiours Will	APR. 28,	1910 ARKA	ŃSAS	
	/land		10a. State 10b. County 10c. City, Town or	Location		10	d. Inside City Limits	
	e Man ta-fsh lifte J	ctor	MD PRINCE GEORGES LANHAM				XXYes 2□No	
	vith the	Director	10e. Street and Number	10f. Zip Code		g. Citizen of What Count	-	
	ns 23s	Funeral	4311 CRELIN PLACE  11. Marital Status 12. Was Decedent Ever in U.S. 13.	20706  3. Was Decedent of Hispanic Origin? (	Specify Yes or No-	JNITED STATE		
21215-0036	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show deal Exar a crimst be notified at	by	1 ☐ Never Married	If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 <b>XCX</b> No Specify:	rto Rican, etc.)	Black, White, e	tc.	
15-0	72 hc	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation we kind of work done during most of w i. DO NOT use retired)	orking 16	6b. Kind of Business/Ind	ustry	
121		duic	Elementary/Secondary (0-12)   College (1-4or 5+)	ABORER		PRIVATE		
d 2	ljed Hyg har nt,	Be C	17. Father's Name (First, Middle, Last)		ame (First, Middle, Ma			
ylar		ToE	THOMAS SLOAN		YA (UNKNOW			
Maryland	2 # C			illing Address (Street and Number or F 11 CRELIN PLACE	Rural Route Number, C LANHAM, M		Code)	
altimore,	Se de la company		20a. Method of Disposition  XXBurial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Discemetery, commentery, commentery, commentery, commentery, commenters,	position (Name of rematory or other place)	Date 20	Oc. Location - City or Tov	vn, State	
ţ	permit. Pages Department of Important: If it any injury or o		`4 □ Donation 5 □ Other (Specify) MARYLAND	NATIONAL CEM. 11		LAUREL, M		
Bal	Depar Impo any ir		21. Signatur of Funeral Service Licensee	22. Name and Address of Facility MARSHALL S FUNER 4308 SUITLAND RO	AD SUITLA	ND, MD 2074		
П		g	23a. Part1. Inter the disease, or complications that caused the death. Do not on shock or heart failure. List only one cause on each line.	enter the mode of dying, such as cardi	ac or respiratory arres	st,	Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. ASPIRATION PNEUM a. ASPIRATION PNEUM PNE	ONIA				
г	Examiner		Due to (or as a consequence of):  DEMENTIA ALZHEI  DEMENTIA ALZHEI	MERS TYPE				
	D ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury					
	be executed sician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):					
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and toge 2 should be detached for use as the burial-transit		d					
99 xo	eath certifica attending pt for use as tl	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Date of deliver		
Во	d for us	lcian	250. Was decorate pregnant in the past 12 months?  1 Vec 2 No. 4 Pregnant at time of death	3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliver	y Day Year	
P.0.	at the de by the a	hys	9 🗍 Unknown		_			
	ires that signed t I be det	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the		
ecords,	w requir been s should	Completed			24a. Was an		sy findings available	
$\mathbf{\alpha}$	The tav	ошо			autopsy performe	prior to com	pletion of cause of	
Vital		Be C	25. Was case referred to medical examiner?	26. Place of De	1  Yes 2X eath (Check only one)		2 140	
of V	Physician: this certificanal director,	၉	1 ☐ Yes XXNo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat			ce 6 Other (Specify)		
on o	After Une	tlon:	27. Manner of Death  XX Natural 5 □ Pending (Month, Day Year)  2 □ Accident investigation (2.1)		28d. Describe how	injury occurred		
Division	l or Attending after death. Diractor: After I in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,	
]	To the Hospital or within 24 hours after to the Funeral Dir	edical Ce	29a. Certifier  (Check only 2 ☐ Medical Examine) On the basis of examination and/or	eath occurred at the time, date and place investigation, in my opinion, death occ	ce, and due to the cau	use(s) and manner as sta	ited.	
	within 24	Med	one)   and manner stated.  29b. Signature and title of certifier	29c. License number		d. Date signed (Month, D		
			11 lup un	D52261		NOVEMBER 28		
	Copo		30. Name and address of person who completed cause of death (Item 23a) (Typ				, 2000	
	9			00 ANNAPOLIS RD.	SUITE A-4	LANHAM, MD	20706	
	Sta Regist		NOV 2 9 2006  32. Registrar's Signature					
DH	MH 17 Rev 1/2	001	ORIGII	NAL				

	For State Ragistrar		State	of Maryla	and / Depa <i>Cei</i>			lealth : Death		1ental F	-	ne O	06	399	12
	1. Decedent's Name (First,	Middle, Las	t)							2. Date of	Death	Day	Year	3. Time of I	Death
Physician /Medical	Eliza	G.	Smith	ı						Nov.	:		2006	5:20	a <sup>M</sup>
xaminer	4a. Facility Name (If not inst	itution, give	street and n	um <i>ber)</i>		4b. City	, Town, or	r Location	ol Death			4c. Count	y of Death		
	Joseph Riche	y Hos	pice				altim								
neral	5. Social Security Number	6. Se	x □M 21&TF		rs. last birthday)	If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of (Month,	Birth Day, Y	ear)	9. Birth	place (State or intry)	Foreign
ctor	243-63-2632			92	Yrs.					Dec.				th Caro	
סחכפר. To Be Completed by Funeral Director	Usual Residence of Decede			10c.	City, Town or Lo	cation								10d. Inside Cit	v Limits
5	DC DC	, a.n.y		1.00										1 X Yes	•
ect	10e. Street and Number				Washing		- Code				100	Citizan	14/hat Cau		
ă		0.	NT TT			10f. Z	p Code	0			109	. Citizen of		intry?	
Funeral Director	1818 Newton	St.		cedent Ever in	11.0	Man Dan	2001		i=i=0 /C=	4. V	- N -	USA		ican Indian,	
Į,	11. Marital Status 1 ☐ Never Married 2 ☐	Marriad	Armed F	Forces?	10.5.	f Yes, sp	ecify Cuba	an, Mexica	n, Puerto	ecity Yes or Rican, etc.	)		ack, White		
by F	3 XWidowed 4 Div		If Yes, G	Sive		1 🗆 Yes	2 🔀 No	Specify:	:			Speci	fy:	Black	
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E	Elementary/Secondary (0 unk	-12)	College	(1-4or 5+)	Cust	odia	ıl Wo	rker			Ge	orget	own	Univ. H	logn
O	17. Father's Name (First, M.	ddle, Last)			, , ,	JOULE	12 110		er's Nam	e (First, Mic					овр.
0	George Grime	s						1a:	ıra R	oach					
ဥ	19a. Informant's Name/Rela	tionship (T	vpe. Print)		19b. Mailir	na Addres	s (Street	and Numb	er or Rur	al Route Nu	ım <i>ber. C</i>	ity or Town	. State. Zi	n Code)	
	Ella G. Hami		•		3915 Balti	Mt.	Wood	Road	20			,	,	,	
1	20a. Method of Disposition	I COII/	NIECE	208	. Place of Dispo	sition (Na	ame of		.29	Date	20	c. Location	- City or T	own, State	
	1 ₺ Burial 2 □ Crema				cemetery, crer	-	-								
1	4 □ Donation 5 □ Oth  21. Signature of Funeral Se			- 1 '	Glenwood					<b>-</b> 2006		shing	ton,	DC	
	21. Signature of Fullering	na	shall	1//	Ň	larsh	all	s Fun	ieral	Home	, In	ıc.	c. Carl constant days of		
	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	June	unus					st. N				on, D	C 20		
	23a. P (p) . Enter the disea shock, or heart failure	List only	one cause on	each line.	sain. Do not ent	er the m	de or dyin	ig, such as	Cardiac	or respirato	ry arrest	•		Approximate Interval Betw Onset and D	reen
	Immediate Cause (Final disease or condition		a	urem	10									years	
	resulting in death)		Due to	o (or as a cons	sequence of):										
Н.	Sequentially list conditions,	- 1	b												
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	~	Due to	o (or as a cons	sequence or):										
Сап	that initiated events resulting in death) Last	1	C	. /	aguanas al\;								-		
Ê	4		Due	o (or as a cons	equence or).										
dical		•	d				-		-						
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Physician/M	23b. Was decedent pregna in the past 12 months'	nt i	1 Live	utcome of pre birth 2 DF	etal death 3 □		oregnancy	,				1	ate of delive		ear
Sic	1 ☐ Yes 2 No 9 ☐ Unknown		4∐Preg 9∐Unk	gnant at time o nown	of death 5	Other (s	pecify)				_			,	
F.	Dati Other simiferes of	ndisions -			and the same of the same of			o in Dead		220 5	Sid takes	-			
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P	MILLINIA	ne go	ungie	nous	ulces					1	Yes	2 No	3 🗌 Pro	bably 4 UU	nknown
pie											Vas an	24b.	Were aut	opsy findings a	vailable
Completed											errorme	d? No	death?		
0	25. Was case referred to m	edical						26. Place	e of Deat	h (Check or					
To B	examiner? 1 ☐ Yes 2 💢 No	- 1	Hospital: 1	Inpatient 2	. ☐ ER/Outpatien	nt_3_ [	OA Oth	er: 4 🗆 N	ursing Ho	me 5 P	Residenc	e 6 <b>2</b>	her (Speci	nospi	ice
	27. Manner of Death	777	28a. Dat	e of Injury onth, Day Year	28b. Time of Injury		28c. Injur Wor	y at		28d. Descri	ibe how	injury occu	rred		
atio		ending vestigation		, Day 1 dai	, injuty	м		Yes 2	No						
Certification:	3 ☐ Suicide 6 ☐ 0	ould not be etermined	200. Flat	ce of Injury - A	t home, larm, str	eet, lacto	ry, office			28f. Locatio	on (Stree	et and Num	ber or Rur	al Route Numb	)9 <i>r</i> ,
ert	4   Hornicide		Duil	ding, etc. (Spe	ecity)					City or	Town, S	otate)			
	29a. Certifier 1 Ca	rtifying Phy	ysician: To the	ne best of my	knowledge, death	n occurre	d at the tin	ne, date ar	nd place,	and due to	the caus	se(s) and m	anner as s	stated.	
edical	(Check only 2 Ma	dical Exam	inar: On the	basis of examinner stated.	ination and/or in	vestigatio	n, in my o	pinion, dea	ath occur	red at the tir	me, date	and place,	, and due t	to the cause(s)	
₩	29b. Signature and title of c	ertifier				2	c. Licens	e number			29d	. Date signe	ed (Month,	Day, Year)	
1	> 5to	0 11					7	774	170		K	love	1.1	74 20	mh
	30. Name and address of p	veon who	completed co	use of death /	tem 23a) /Tues	Print\	Ţ	1-1	, ,,		1	NUVEW	ner	24, 21 D 212	200
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	31. Date filed (Month, Day,	Year)	32	Registrar's	natur	0 0	, ,	· LI	an	71	[M]	IMOY	LMI	1 44	
State sistrar	NOV 2 9 2006	1		A. Do	we										

11/33/06

State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician HERBERT LEON SLAUGHTER NOVEMBER 2006 6:24 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, DEC 30 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1**ĕ**M 2□F Hours 579-54-3596 65 Director 1940 VIRGINIA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Director 1 Yes 2 No PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7905 TYLER STREET 20706 "natural", or items 23a U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation permit Pages 1 and 2 should be filed within 7. Department of Health and Menial Hygiene. Important: if item 27 ie marked other than "na eny injury or other traumatic event, the Medica 2008. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th SCREEN PRINTER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ERNEST H. SLAUGHTER ARLENE GIBSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7905 TYLER STREET LANHAM, MARYLAND 20706 REATHER SLAUGHTER/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) FT. LINCOLN CEMETERY 11/30/2006 BRENTWOOD, MARYLAND 21. Signature of Furre at Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final CARDIAC ARRHYTHMIA Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) the attending physician hed for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown à been signed I should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Munknown page 2 should Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate has 1 Yes 2 No After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No il Director: A investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 ☐ Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m who completed cause of beath (Item 23a) (Type, Print) 32. PATISTRA JOHN HOSPITAL CHEVERLY, MD 207

DHMH 17 Rev 1/2001

Registrar

			For State	State of	of Maryla		artment of F rtificate of i		_	2000	39914
J.			Registrar  1. Decedent's Name (First, Middle, La	et)		Cei	unicale or i	Dealli	2. Date of De		3. Time of Death
Ö.	Physicia			ITH					Month	Day Yea ER 24, 200	r M
	/Medic Examin	14	4a. Facility Name (If not institution, giv	e street and nu	ımber)		4b. City, Town, or	Location of Deat		4c. County of De	
			FREDERICK MEMORI				FREDERIC			FREDERI	
	Funeral		5. Social Security Number 6. S	ex □M 2√2 F	7. Age (In yr	s, last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, Da	ay, Year)	irthplace (State or Foreign Country)
×'	Director		Usual Residence of Decedent	**					Oct. 2	2, 1941 M	aryland
	iryland ihow		10a. State 10b. County		10c. 0	City, Town or Lo					10d. Inside City Limits  X☐ Yes 2☐ No
	he Ma 18a-f s otified	Director	<u> </u>	erick		Fre	derick			10g. Citizen of What	
	with ta or 2	ă	10e. Street and Number				10f. Zip Code	1701			,
	ms 23	nera	5 Hamilton Ave.  11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	Was Decedent of H If Yes, specify Cuba	21701 ispanic Origin? (S	Specify Yes or No	United S	nerican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 ☐ Never Married 2 📆 Married 3 ☐ Widowed 4 ☐ Divorced	Armed F 1 ☐ Yes If Yes, G Year or I	ive No		1 □ Yes 2√□ No	Specify:	to filcan, etc.)		White
21215-0036	'2 hou natura ical E	ted	15. Decedent's E (Specify only highest gr	ducation	)	16a. Dece	dent's Usual Occup	ation	rkina	16b. Kind of Busines	ss/Industry
2	ithin 7 ne. Med	Completed	Elementary/Secondary (0-12)		(1-4or 5+)	I	kind of work done of NOT use retired memaker	i)	, naig	Own	Home
7	iled w Hygier ther th	S	11 17. Father's Name (First, Middle, Last	<b>)</b>		110	memere E	18. Mother's Nai	me (First, Middle	n, Maiden Surname)	
Maryland	ld be fental iked or	To Be	William E. J					Bertha	a Schaff	er	
ary	shou and M s mar		19a. Informant's Name/Relationship			I .				per, City or Town, State	, Zip Code)
Σ	and 2 ealth a n 27 l		Jeanette Stottle	myer /						MD 21701	
ore	ges 1 it of H if Iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from	State		sition (Name of matory or other plac	1	Date	20c. Location - City	
altimore,	iit. Pa artmer ortant: injury		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		R		n Cemeter 2. Name and Addre		28/2006   Stauffe	Freder r Funeral	ick, Maryland
Ba	Department of the service of the ser	Ш	Now meet	touk	Res			_		Frederick	
			23a. Part1. Enter the disease, or com shock, or heart fallure. List only	plications/that	caused the de	eath. Do not ent	ter the mode of dyir	ng, such as cardia	c or respiratory a	arrest,	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Doe to	(or as a cons	equence of):	,				
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	ecuter and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	(or as a cons	aguence of):					
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Φ	ifficate g phys as the	edic		<b>-</b> d							
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o.	that the dea ned by the at detached fo	Physician/Me	1 ☐ Yes 2 Solo 9 ☐ Unknown	4□Preg 9□Unk	nant at time o	of death 5	Other (specify)			Wichti	Day Tour
<u>α</u>	w requires that s been signed b should be deta		Part II. Other significant conditions		\ .		nderlying cause giv	ren in Part I.	23e. Did		to the cause of death?
ord	require sen signould b	ted I	Chronic K	idney	dis	6026	stage	tive	1	Yes 2 No 3	Probably 4 Unknown
or Vital Records,	has	Completed by							24a. Was auto perfi 1 Yes	opsy prior t ormed? death	autopsy findings available o completion of cause of ? es 2  No
ta		BeC	25. Was case referred to medical examiner?					26. Place of De	ath (Check only		2 710
7 \	% .o :⊟	To	1 ☐ Yes 2 ZONo			ER/Outpatie		4 ☐ Nursing I		idence 6 Other (S	pecify)
	ding F	ion:	27. Manner of Death  1 ☑ Acrident  2 ☐ Acrident investigation	(Mo	e of Injury nth, Day Year,	28b. Time o Injury	Wor	ryat rk? Yes 2 □ No	28d. Describe	how injury occurred	
Division	Attending r death. ector: After by the fune	ficat	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	e 28e. Plac	e of injury - At	home, farm, st	reet, factory, office		28f. Location (	(Street and Number or own, State)	Rural Route Number,
ā	ital or rs afte ral Dir led in l	Certification:							ļ		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral.	edical		miner: On the						e cause(s) and manner , date and place, and c	
	To the within 2 To the comple	Me	29b. Signature and title of certifier				29c. Licens			29d. Date signed (Mo	onth, Day, Year)
) ,	`		· Cauli Ja	essut	<u></u>			05689	0	11/36/00	Ω
C	4		30. Name and address of person who	completed car	use of death (I		Print) Dr.	nemia	in	21716	
	Sta	ite	31 Date filed (Month Day Year)	000 32.	egistrar's Sig	gnature	105 216	(10010)	C, IND	01116	
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		For State Registrar		State o	of Marylar		artmen <i>rtificat</i>			nd M	-	giene	06	39915
		Decedent's Name (First, Management)	iddle, Last)								2. Date of De.	ath	V	3. Time of Death
Physicia /Medic		Willi	am C	urtis	Smulle	en				1	Nov. 2	8, <sup>Day</sup> 200	6 Year	9:30 PM M
Examin		4a. Facility Name (If not institu	ıtion, give s	treet and nu	ımber)		4b. City,	Town, or	Location of D	Death		4c. Cou	nty of Death	
		12578 Recycle	Driv	е			Pr	inces	ss Anne			Som	erset	
Funeral Director		5. Social Security Number 213-44-2425	6. Sex	M 2□F	7. Age (In yrs. 61	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Hrs. Min.	8. Date of Birt (Month, Da Feb. 8,	1945	Cou	place (State or Foreign ntry) y Land
p ,		Usual Residence of Decedent 10a, State 10b, Cou			10c Ci	ty, Town or Lo	antion							10d. Inside City Limits
sho	5		•											1 ☐ Yes 2 XNo
28a-f	ect	Maryland   Som	erset		Pr	incess	Anne 10f. Zip	Code				10g. Citizen	of What Cou	ntry?
with the control of t	直	12578 Recycle	Driv	A			101. 210	2185	53			U.		,
leath ns 23	era	11. Marital Status		2. Was Dec	cedent Ever in U	J.S. 13. V	Was Deced			1? (Spe	cify Yes or No		lace - Ameri	can Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic svent, the Medical Examinar must be neilling at once.	by Funeral Director	1 Never Married 2	Married	Armed F	orces? 2 □ No ive		f Yes, spec 1 ☐ Yes	14	n, Mexican, P Specify:	Puèrto i	icify Yes or No Rican, etc.)	Spe	Black, White, cify: Wh	etc. ite
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nd 2 sho alth and 27 is ma ir traum		19a. Informant's Name/Relati Grace E. Smu					-				Princes			
Pages 1 and nent of Herant		20a. Method of Disposition 1  Burial 2 Cremati		emoval from	State	Place of Dispo cemetery, crer Salisbu	natory or o	ther place			ate	20c. Locatio	on-City or T	
artme orten injury	,	`4 □ Donation 5 □ Othe  21. Signature of Funeral Serv		96					s of Facility	-	inman E			114.
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		23a. 11. Enter the disease	or compli	cations to t	caused the dea								, ,	Approximate
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cate be executed obysician end the burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events										w.,		
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w requires that the de been signed by the should be detached	P	Part II. Other significant con	ditions con	tributing to	death but not res	sulting in the u	nderlyina c	ause aive	en in Part I		23e. Did to	obacco use c	ontribute to t	the cause of death?
signe d be d	d by	arring data of the second									15%	Yes 2□No	3 ☐ Prol	bably 4 □Unknown
requ	Completed										240 1450	04	h Mass sut	
e law has l	mpl										24a. Was autor		prior to co death?	opsy findings available ompletion of cause of
n: Th icate r, pa(											1 Tyes	2 No	1 🗆 Yes	2 No
Physicien: The law r this certificate has t ral director, page 2 s	o Be	25. Was case referred to med examiner?  1 Yes 2 No	-	ospital:	Inpatient 2	TED/Outpotion	nt 3 🗆 DC	Othe	r		(Check only o		Dub / (C)	(, 4
Phy r this ral d	$\vdash$	27. Magner of Death		28a. Date	of Injury	28b. Time of		8c. Injury	at	- 1	ne 5 X Resid 28d. Describe I			ry)
ding th: Afte fune	tlor	1 Natural 5 Pe	nding estigation	(Moi	nth, Day Year)	Injury	М	Work 1 □ \	(? Yes 2 ∐ No	,				
Atten deal octor	fica	3 ☐ Suicide 6 ☐ Co	uld not be termined	28e. Plac	e of Injury - At h	ome, farm, str	eet, factory	, office		1			mber or Rur	al Route Number,
after Dire	Certification:	4  Homicide de	(011111100	build	ding, etc. (Speci	fy)					City or Tox	wn, State)		
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C			sician: To the land man	e best of my knobasis of examination	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my op	e, date and pointon, death	place, a	and due to the ed at the time,	cause(s) and date and plac	manner as s	stated. to the cause(s)
To the within To the	Me	29b. Signature and title of cer	difier		1)		290	. License	number	,	^	29d. Date sig	ned (Month,	Day, Year)
		> C 80	00	nen	h	12		0	25	21	9	//	- 69	Day, Year)
		30. Name and address of per	son o co	mpleted cau	use of death (Ite	m 23a) (Type,	Print)	7 1			0.0	7		641
		21 Date filed (Month Day V	175 m	~6~	Pagintrada Sina	aturo	/_	アナし	er po	01	les, F	in cc.	SSH	nne, Nid
Sta Registr		31. Date filed (Month, Day, Y		32.	negistrar's Sign	ALUIN ALUIN	Anne	K.,						•
ricgisti	ul	DEC	042	006	معلاهلا	Jr /								

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend#24a Per Phy. State of Maryland / Department of Health and Mental Hygiene Registrar AACO Health Dept. 11/22/06 CMH Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Scott Carol 9619 November 13, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Hospital Security Number 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F 082-48-6256 Yrs. Apr. 18, 1953 NY Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28e-f ehow the Medical Examiner must be notified at DE Kent 1 ☐ Yes 2 No Funeral Director Smyrna 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 378 North High Street 19977 USA death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or iteme 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Depertment of health and Mental Hygiene. If them 27 is marked other than "naturel", or item any injury or other traumatic event. the state of the traumatic event. 1 ☐ Never Married 2 ☑ Married Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Webber Patricia A. Bell ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Scott/Husband 378 North High Street, Smyrna, DE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Nov. 18, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sharon Hills Mem. Pk. Dover, DE 4 ☐ Donation 5 ☐ Other (Specify) 2006 Signature of Juneral Service Linens Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. 1. Ster the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, in heart failure. List of ty one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or candition resulting in seath) **Physician** Aspiration pneumoniti 20 minuty /Medical Due to for as a consequence of): **Examiner** Sequentially list conditions, if any leading 15 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner or Attending Physician: The law requires thet the death certificate be executed burial-transit Due to lo as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Vunknown Be Completed 24a. Was an autopsy performer 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1∰Yes 2⊠No After this certification, funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1/Z Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mapher of Death 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred 1 Naturai 5 🗀 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Medical Voctor Kes -000 November 13,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wife Street, Baltimore, Maryland 21287 Johns Hopkins Hospital 31. Date filed (Month, Day, Year) NOV 2 32. Registrar's Signature State 2 2006

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 27, 10:30 A<sup>M</sup> Grant Snyder November 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 13℃ M 2 ☐ F 86 068-16-7096 May 18, 1920 New York Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County MD Director Montgomery Gaithersburg 1 TYYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Russell Avenue, 20877 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1941- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 TYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No 1968 1 ☐ Yes 2 ☐ No Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Air Force 5 + Chief Master Sergeant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ray Snyder Charlotte Purdy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Russell Avenue #1008 Gaithersburg, MD 20877 Artha Jean Snyder (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. 2 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State North Potomac, MD Darnestown Presbyterian 2006 Ъ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Devol Funeral Home 21. Signature of Funeral Service-L 10 E. Deer Park Drive, Gaithersburg, MD. 20877 Part . Ehler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Years disease or condition resulting in death) Parkinsonism Sequentially list conditions, if any, leading to immediate cause. Enter Underf, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h. Was decedent pregnant ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ₹ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 □ Yes 2□No 1∐ Yes 2 🙀 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4√2 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 1 Inpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No

executed Division or Vital Records, P.O. Box 68760, •pital or Attending Physician: The law requires that the death certificate be usurs after death.
usurs after death.
reral Director: After this certificate has been signed by the attending physician filled in by the tuneral director, page 2 should be detached for use as the buring that the purity or the pur

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician

/Medical Examiner

nding physician and use as the burial-trans

Baltimore, Maryland 21215-0036

within 24 hours a Medical To the I 20+1

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

6 Could not be

determined

29c. License number D20148

1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Dav. Year) November 28, 2006

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

911 Russell Avenue

Gaithersburg MD.

State	31. Date filed (Month Cay	Year)	2000
istrar	WO V	W J	2000

Steven Dolinsky

gistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

		For State	State of	Marylan	-	rtment <i>tificate</i>			and Mer		iene	106	39918	
	7	Registrar  1. Decedent's Name (First, Middle,	, Last)					- Cati	2.	Date of Deat	th		3. Time of Death	_
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/Medi Examii		4a. Facility Name (If not institution,	give street and numb	per)		4b. City, T	own, or	Location of	of Death		4c. Co	unty of Death		
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Funeral			6. Sex 7. 1 X M 2 □ F	. Age (In yrs. I	as <i>t birthd</i> ay) Yrs.	If Under 1 Months	Year_ Days	If Under I	Min.	Date of Birth (Month, Day,	Year)	9. Birth		
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	/ A		VVIVNEa	WING	VIKU	Vtle		10	07	TO	5	11/16/2	2006	
l	10		30. Name and address of person who MELISSA LYNN MEANS:					WEST F	BETHES	DA, MA	ARYLAND 20	0827	,	
	Sta Registi		31. Date filed (Month, Day, Year)		gistrar's Signa									

90/91/11

			1 - State Registrar	State of M	faryland /		rtment of H		nd Me		giene Reg. No. 2006	39920
			Decedent's Name (First, Middle, Last	st)					2	. Date of Dea	ath	3. Time of Death
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1	/Medic Examin		4a. Facility Name (If not institution, give		r)		4b. City, Town, o	or Location of	Death		4c. County of De	
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ဗ္ဗ	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2 🕱 No	Specify:			SpecifyB1 a	ack
ŏ	within 72 hours after death with the Maryland ene. Itan "naturel", or items 23a or 28a-f ehow he Medical Examinar must be notified a	Completed	15. Decedent's Ed		10		ent's Usual Occup		adadvina		16b. Kind of Busines	ss/Industry
215	hin 7	ple	(Specify only highest gra	College (1-4or	r 5+)	life. C	kind of work done OO NOT use retire	d) most	or working			
7	or th	6	7		,	Но	tel Work	er			Hotel	
g	se filed al Hygi f other vant, t	Be (	17. Father's Name (First, Middle, Last)					18. Mother	's Name (i	First, Middle,	Maiden Sumame)	
<u>Va</u>	Mental Merkad o arkad o	0	Benjamin Samuel					Alic	ce Sa	muel		
Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental hygiens. Indicate the mass 28 or 28s-1 show limportant: If fem 27 is marked other than "naturel," or items 28s or 28s-1 show any Injury or other traumatic evant, the Medical Expinition number anothlist at DDCs.		19a. Informant's Name/Relationship	**							r, City or Town, State	
2	and ealth m 27		Herman A. Samuels	;/ Son			Telephone Control	station				oro, MD 20774
Baltimore,	or off		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑	Removal from State	come	of Dispos etery, crem	sition (Name of natory or other pla	сө) г	Dat Dec.	. 18	20c. Location - City	or Town, State
Ē	Peg ment ant: ury c		4 ☐ Donation 5 ☐ Other (Specific			cliff		į	200		Hartsdale	e, New York
a	permit. Depert Import Iny Inj DDCE.		21. Signature of Funeral Service Licen	see		22 F	Name and Addre	ss of Eacuity	lins	Funera	1 Home Inc	3.
_	202 9 9		13 comps	Done		5	00 Unive	rsity	Blvd	, W, S	ilver Spri	ing, MD 20901
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only			o not ente	or the mode of dying	ng, such as c	cardiac or r	espiratory ar	rest,	Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition	a. Pneumon	nia							Onset and Death
	/Medical Examiner		resulting in death)		s a consequen	ce of):						
		_	Sequentially list conditions,	b. Chronic	Kidney	y Dis	ease					
	sit 9d	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequent	ce ot).						
	end Fran	хап	that initiated events resulting in death) Last	c. He cut f	s a consequenc	ce of):						
8760,	be ey icien buria	E I		·	lopathy	•						
87	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physicien end rat director, page 2 should be detached for use as the burial-transit	dical		. d	[	<u></u>						
9 X	leath certifi attending p	Physician/Me	IF FEMALE:	23c. If yes, outcom	e of pregnancy						22d Date of a	tolina.
Вох	atten for u	slan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal dea	ath 3 🗌	Ectopic pregnancy Other (specify)	У			23d. Date of d Month	Day Year
P.O.	the d	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	at third or death	, ,,,	Olifer (specify)					
۳.	w requires that the de been signed by the should be detached	F.	Part II. Other significant conditions c	ontributing to death	but not resultin	g in the un	derlying cause giv	en in Part I.		23e. Did to	bacco use contribute	to the cause of death?
ds	uires sign d be	d by	Hypothyroidism							1 🗆 Y	'es 2□No 3□	Probably 4 QUnknown
Ö	w req beer shou	Completed								24a. Was	an 24h Were	autopsy findings available
Re	has ge 2	du								autop	sy prior t med? death	o completion of cause of ?
ā	n: Ti	e Cc	25. Was case referred to medical					00 01	-4 D4b- (1			es 2 No
⋚	sicia s cert irect	<b>60</b>	examiner?	Hospital:	tient 2 TEP/	Outpatient	3 DOA OU	105		Check only o	<i>ne)</i> lence 6 ∐Other (S <sub>I</sub>	
Division of Vital Records,	Phy or this oral d	): To	27. Manner of Death	28a. Date of Inj	jury 28t	b. Time of	28c. Injui	4 LANUIS			iow injury occurred	seciny)
0	th.	tlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	lay Year)	Injury		rk? ∣Yes 2∐N	lo			
/isi	Attending or death. actor: After by the fune	flea	3 ☐ Suicide 6 ☐ Could not be	286. Place of it	njury - At home	, farm, stre	et, factory, office		28		Street and Number or	Rural Route Number,
ă	al or A after I Dira	Certification:	4 Homicide	building, e	etc. (Specify)					City or Tow	m, State)	
	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	alc	29a. Certifier 1X Certifying Ph	ysician: To the bes	t of my knowled	dge, death	occurred at the ti	me, date and	place, and	d due to the	cause(s) and manner	as stated.
	the Ho hin 24 I the Fu npletely	edical	(Check only 2 Medical Examone)	niner: On the basis and manner s	of examination stated.	and/or inv	estigation, in my o	opinion, death	h occurred	at the time,	date and place, and d	ue to the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier	11-111			29c. Licens	-			29d. Date signed (Mo	
)	/		What A	tella	Mo	$\supset$	Do	062	591	4	11/28/	2006
	$\varphi$		30. Name and address of person who	completed cause of	death (Item 23	a) (Type, I	Print)			_	*	
_			NASHAT	AIA	LLA	752	5 Greenw	ay Cen	ter [	Drive,	Greenbelt	,MD 20770
	Sta		31. Date filed (Ment) Pay 2'09) 2(	Regis	trar's Signature	100	de s					
	Registr	ar		1000		-						

		1	_ FOI	partment of Health and M ertificate of Death		iene 006	39921
			Decedent's Name (First, Middle, Last)		2. Date of Deat	h	3. Time of Death
	Physici /Medio		CAROL SPARSHOTT STOCKMAN		DECEME	SER 8,200	6 2:55PM™
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deal	th
			CALVERT MEMORIAL HOSPITAL	PRINCE FREDER		CALVER	
	Funeral		5. Social Security Number  6. Sex  1 M 2XX  7. Age (In yrs. last birthd.	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Co	hplace (State or Foreign
	Director		220-42-0858 Usual Residence of Decedent		AUG.29	,1945 WA	SH.,DC
	anyland show		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	the Maryla r 28a-f ehov	tor	MARYLAND ST.MARY'S HOLLY	WOOD .			1 ☐ Yes XXNo
	ith the M or 28a-f	Directo	10e. Street and Number	10f. Zip Code	10	0g. Citizen of What Co	ountry?
	th will		24425 LAKELAND DRIVE	20636		U.S.A.	
	72 hours after death with the Maryland natural; or iteme 23a or 28a-f ehow deat Examinat must be nutiliad at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ol><li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li></ol>	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9	or it	by Fu	1 □ Never Married 2 XXMarried 1 □ Yes 2 XXNo   IYes, Give   Year or Dates:	1 ☐ Yes 2XXo Specify:		Specify: TAT	HITE
5-0036	tural al Ex			cedent's Usual Occupation		16b. Kind of Business	
Ċ	in 72	Completed	(Specify only highest grade completed) (G	ive kind of work done during most of work e. DO NOT use retired)	ing	TOD. TAILE OF DESITIONS	Middatty
2	within isone.	mo	Elementary/Secondary (0·12) College (1·4or 5+)	TTTER CARRIER	r	ו כ מרפידי	AL SERVICE
Ö	illed Hygi other	0	17. Father's Name (First, Middle, Last)	18. Mother's Nam			AD OMEVICE
Maryland	Menta Menta Med Mic ev	To B	ROBERT EMERY SPARSHOTT	ISABEL	LE ANNE	ADAMS	
a Z	should and Men s marke umatic			ailing Address (Street and Number or Run	al Route Number.	City or Town, State,	Zip Code)
	and 2 eaith a n 27 le			BOX 252, HOLL	YWOOD,	MD 20636	
ore O	一工资量		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Discemetery, 6	sposition (Name of crematory or other place)	Date	20c. Location - City or	Town, State
Ĕ	Pag nent int: f		4 □Donation 5 □ Other (Specify) ST. FRANC	S XAVIER CH.CEM	. 12-15	-06 NEWT	OWNE, MD
Baltimore,	permit. Departrimporte any inju		m(1-104	22. Name and Address of Facility RAYMOND FUNERAL			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not	enter the mode of dying, such as cardiac	AND 206 or respiratory arre	946 est,	Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	0.10.	A.C.		Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	Ovarian conce	<b>/</b> 4		weeks
	Examiner		fungenia				days
Ļ		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying.				
/	cuted nd ransi	Examin	cause. Enter Undertying Cause (Disease or injury that initiated events c.				
õ	be executed sicien and burial-transit	Ä	resulting in death) Last Due to (or as a consequence of):				
8760	ate b hysic the bu	dicai	d.				
٥	The law requires that the death certificate tie has been signed by the attending physoage 2 should be detached for use as the	Mec	IF FEMALE:				
Box	ath c	Physician/Me		3 □Ectopic pregnancy		23d. Date of de Month	livery Day Year
o.	res that the de igned by the a be detached f	ysic	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)			
٥.	that the	F.	Part If. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part f.	23e. Did tob	pacco use contribute to	the cause of death?
ds,	signe d be	d by	small bowel obstruction	, , , , , , , , , , , , , , , , , , , ,	1 □ Ye	s 2 No 3 P	robably 4 Unknown
Division of Vital Records,	w requir been si should I	Completed	1:1		Odo Who a	245 144	standard and laborate
ě	The law	ш	signetes mellitus, type c		24a. Was a autops perform	y prior to death?	topsy findings available completion of cause of
<u>a</u>					1 ☐ Yes 2	2 □ No 1 □ Yes	212 No
₹	ysician: is cartific director,	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Deat			
ō	Phys raldi	2	1  Yes 2  PNo	tient 30 box 4 Nursing Ho		once 6 Other (Spe	city)
O	ding th. Afte fune	ţ	1 ☑Natural 5 ☐ Pending (Month, Day Year) fnju 2 ☐ Accident investigation	ry Work? M 1 ☐ Yes 2 ☐ No		,	
ls!	Attending Physician: or death. ector: After this certification is the funeral director.	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	street, factory, office	28f. Location (St	reet and Number or Ri	ural Route Number,
Š	after Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town	n, State)	
	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o	eath occurred at the time, date and place, r investigation, in my opinion, death occur	and due to the ca red at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	ithin ( the o the	Med	29b. Signature and title of certifier	29c. License number	25	9d. Date signed (Mont	h, Day, Year)
	F ≱ F 8		M mo	060390		12/9/20	
r	_		30. Name and address of person who completed cause of death (Item 23a) (Ty			- 112	
	U		ADEED JABER 100 HOSPITAL	^	26060.0	- 1000 7	.0678
	Sta	ite	31. Date filed (Month, Day, Year) 32 Registrar's Signature	A .	CVEILL	L IVIN L	/ 0
	Regist		DEC 1 4 2006 Line & A	mell			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Elizabeth 1:35 PM 2006 Dec /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death of Maryland Medical Center MIVEYSITU Battimore 5. Social Security Number Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 215-34-0944 Days 1 □ M 2 X F Hours Director 16 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10h. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD. Harford 1 ☐ Yes 2 No Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2800 Scarff Road Completed by Funeral 21047 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Activity Therapist Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Koller other traumatic Harry Marie Lauterbach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 is R. Wilson Scarff/Husband 2800 Scarff Rd. Fallston, Maryland 21047 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Department o Important: If any injury or once, Air Mem. Gardens 12/8/2006 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bel permit. 22. Name and Address of Facility 21. Signature of Funeral Device Licenses Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) day /Medical Due to (or as a consequence of) Examiner Mesenteric schemen Sequentially list conditions, if any leading Lammade, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 □Unknown Completed 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No certificate has autopsy performed? Yes 2 \sum No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient Certification: To 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation 2 Accident ours after death.

neral Director: A
filled in by the fu 1 Tyes 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 16781 Dec 5 2006 MO STUMP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stump Amy 31. Date filed (Month, Day, Year, Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

DEC 1 4 2006

06-09229 George Stephens

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

George Otepher		1- For State Registrar	le of ivial yland		ficate of		a Wierite	, 0	eg. No. 200	5 3002
Physicia Medical Exami		Decedent's Name (First, Middle,	,					2. Date of Dea Month Decembe		3 Time of Death — 1410 hrs
	1101	George Stephe 4a. Facility Name (if not institution,		r)	4	lb. City, Town, or I	Location of		4c. County of Dea	
		Peninsula Regional Me				Salisbury			Wicomico	
Funeral Director		216-54-9345	7. A	ge (In yrs lasi	t birthday) Yrs.	If Under 1 Year Months Days		8 Date of Bir Min. 10/21,	th(MM/DD/YYYY) 9 E Fore /1963	
any		Usual Residence of Decedent  10a. State  10b. County		10c. City, To	own or Location	on				10d Inside City Limits
and show a	ក	Maryland   Wicomi	co	Salis	sbury					1 X Yes 2 No
Maryla : 28a-f	rect	10e. Street and Number			_	10f. Zip Code		1	0g. Citizen of What Co	ountry?
ith the	a Di	29992 Deer Harb	or Dr.	at Ever in II S	13 \//2	21804	pania Origin	? (Specify Yes or No	USA	erican Indian, Black,
ID 21215-0036 s should be filed within 72 hours after death with the Maryland and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f show natic event, the Medical Examiner must be notified at once.	by Funeral Director	1 Never Married 2 X Marr	ried Armed Forces		If Ye	es, specify Cuban,	Mexican, P		White, etc.	
hours a	ed b	15. Decedent's Education (Specification)	y only highest grade co			's Usual Occupations of working life.			16b. Kind of Busines	s/Industry
136 hin 72 e. than "	Completed	Elementary/Secondary (0-12)	College (1-4 or	· I	hief (	perating	r Offi	cer	Seafoo	d Business
5-00 led wit Hygien other the Me	S	17. Father's Name (First, Middle, L			J.1.1.C.L. (			Name (First, Middle, I		a babiliebb
D 21215-0036 should be filed within 7 and Mental Hygiene it is marked other than artic event, the Medical	o Be	Robert L. Steph 19a. Informant's Name/Relationship	ens		10h Mailing			ia Oakley	nber, City or Town, Sta	to Zio Codo)
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after and of the filed within 72 hours after than of Fleakh and Mental Hygiene famt. If iten 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	ř	Gail S. Stephens							ury,Maryla	
Baltimore, MD permit. Pages 1 and 2 shu Department of Health and Importants. If item 27 is injury or other traumat		20a. Method of Disposition  1 X Burial 2 Cremation	3 Removal from S		ace of Disposi ematory or oth	tion (Name of cerr er place)	netery,	Date	20c Location - City	or Town, State
Baltimore, bepartment of He Important: If ite		4 Donation 5 Other Spe	cify:	I	con Cen			.2/8/06	Hebron, Ma	ryland
Balt permit Depart Impor injury		Signature of Fu eral Service Li	cens		HO.1	ame and Address	ineral	Home P.A	ry,Maryland	1 21804
Physician		3a. Part I. Enter the disease, or of failure. List only one cause or	emplications the se	d the death. D						Approximate Interval
/Medical Examiner	4	Immediate Cause (Final disease	a		cations	of head in	jury			Between Onset and Death
j		or condition resulting in death)	Due to (or as a con b.	sequence of):						
S. B. W. W. C.	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con-	sequence of):						
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760, reate be executed physician and the burial - transit			d							
'60, ate be er ohysiciar ne burial	Medical	X UNPENDED	AMENDED #2			rME, g862,	12/16/	<u>/06 TT</u>	23d. Date of delive	
Box 68760, death certificate be executed he attending physician and of for use as the burial - transi		23b Was decedent pregnant in the past 12 months?	1 Live birth		<sub>2</sub> Fet	al death 3	Ectopic p	regnancy	Month Month	Day Year
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of Vital Records, P.O. Box 68: ing Physician: The law requires that the death certificate has been signed by the attending luneral director, page 2 should be detached for use as it.	y Phy	Part II. Other significant condition	ns contributing to dea	ith but not resu	ulting in the u	nderlying cause gi	iven in Part	1. 23e. Did to	bacco use contribute t	o the cause of death?
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cord aw req has bee 2 shou	Completed							24a. Was autop		autopsy findings available completion of cause of
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter death  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach	o Be	examiner?  1 ✓ Yes 2 No	Hospital: 1 / Inpat	ient 2 E	R/Outpatient		Othor -	heck only one)  Jursing Home 5	Residence 6 Oth	er:
of of ing Phy	n: To	27. Manner of Death	28a. Date of In (Month, Day	jury 2 Year)	8b. Time of In	' '  ' '	y at Work?	cubicet i	now injury occurred	oving vehicle
Sion Vittendi death cctor:	atio	Natural 5 Pendin 2 X Accident Investig	gation FIIC 12/4		nd 11:5	) hill	es 2 X N			
Divi	Certification:	3 Suicide 6 Could determ	not be	major/hi		t, factory, office bu	uilding, etc.	or Town, S	tate) 26th St. 8	Rural Route Number, City  Rhiladelphia
Division of Vital Records, P.O. I to the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical Ce	29a Certifier 1 Certifying Phy	sician: To the best of riner:On the basis of ex	ny knowledge amination and	death occurr			, and due to the caus		
T € 100	ğ	29b. Signature and title of certifier	and manner stated			29c License	number	_	29d Date signed (M	onth, Day, Year)
		Joisho !	Jeen 1	n		O.C.N	И.Е. 		December 6, 20	006
		30. Name and address of person w Tasha Greenberg MD.	ho complete Lause of Assistant Medic	,	· ·	Penn Street, E	Baltimore	MD 21201		
<u></u>	ate	31. Date filed (Month, Day, Year)		ar's Signature		J Ouest, L		, 21201		
Regis		DEC 0 8	2006	tow d	y So	ade	-			
DHMH 17 Rev 1/2	001				ORIGINAL					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 30, 8:50 A Susie Mary Thompson 2006 /Medical November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 23140 Cobblestone Lane California 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2XF Months Days Hours Director 578-14-8059 91 Jan. 02, 1915 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23140 Cobblestone Lane 20619 United States Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 □ Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene, Important: If Item 27 is marked other than any Injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John D'Ambrosio Mary Slavaggi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. Spencer/Daughter 4550 Spencer Pl., Nanjemoy, Maryland 20662 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 4, 2006 4 Donation 5 Dother (Specify) Brentwood, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) - Mgestive **Physician** /Medical Due to (or s a consequence of): SOMin Bundle branch Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed phonon physician at s the burial-t Division or Vital Records, P.O. Box 68760 NTRILIUMR Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 1∐ Yes 2 No rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Ansidence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: a 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide l 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature at

State Registrar 31. Date filed (Month, Day, Year)

DEC 0 4

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

24035 Three Notch Road, Hollywood Maryland 20636

32. Registrar's Signature

Blow

D23634

V.K. Shah,

November 30, 2006

		For State Registrar	State of Maryland		rtificate o			Reg. No		39925
Physicia		1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	Da		3. Time of Death
Medic/ Examin		BRENDA JEAN TAYLO  4a. Facility Name (If not institution, give			4b. City, Town	n, or Location of	NOVEMBE		3, 2006  County of Death	0:30A
	Ū.	9565 SYLVAN STIL	ROAD		LA	UREL			PRINCE (	GEORGES
uneral		5. Social Security Number 6. Se	TM WINE		If Under 1 Ye Months Day		Min. (Month, Da)	h y, Year)	9. Birth	place (State or Fore intry)
rector		427 96 2886 Usual Residence of Decedent	6	1 113.			JAN. 22	2, L	945   WAS	HINGTON, D
how		10a. State 10b. County	10c. City,	Town or Lo	ocation					10d. Inside City Lim
8a-f s	Director	MD PRINCE (	GEORGES LA	UREL						XXYes 2⊡1
"natural", or Itama 23a or 28a-f show edical Examiner must be notified at		10e. Street and Number	DD #M		10f. Zip Cod			-	izen of What Cou	
ma 23	Funeral	9565 SYLVAN STIL 11. Marital Status	12 Was Decedent Ever in U.S.	13.		723 of Hispanic Origin	n? (Specify Yes or No- Puerto Rican, etc.)		NITED ST 14. Race - Amer	ican Indian,
or Ita	Fur	1 Never Married 22 Married	Armed Forces? 1 ☐ Yes AM No If Yes, Give	- 1	If Yes, specify C 1 ☐ Yes 2XX		Puerto Rican, etc.)		Black, White	
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8 8		19a. Informant's Name/Relationship (7	10				or Rural Route Numbe	er, City o	or Town, State, Zi	p Code)
itam 27 othar tr	1	JOHN L. TAYLOR /	20b. Plac	ce of Dispo	sition (Name of	STIL RD.	. #M LAT		MD 206	
= 5		XX Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State cen	netery, crei	matory or other p	olace)				
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any ir		MY. Ma	uhll	- 1	MARSHAL	L'S FUNI ITLAND I	ERAL HOME (	OF M TLAN	ARYLAND, D. MD 20	INC. 1746
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signed by the a	by PI	Part II. Other significant conditions co	ontributing to death but not resulti	ng in the u	nderlying cause	given in Part I.	23e. Did to	obacco u	use contribute to	the cause of death?
been sig should b		PNEUMONIA					1 🗆 Y	∕es X	<b>X</b> No 3 □ Pro	bably 4 □Unknov
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pag	Con						perfór 1 □ Yes	rmed? 2XXNo	death?	2 🗆 No
is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other	f Death (Check only or			
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To tha complet	Med	29b. Signature and title of certifier	and manner stated.			ense number			te signed (Month,	
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5	1	30. Name and address of person who o	corn leted cause of death (Item 2	3a) (Type		057275		NOVI	EMBER 25	, 2000

State of Maryland / Department of Health and Mental Hygien@ () () 5 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year ROBERTA TOLSON 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CRESENT CITY NURSING HOME PRINCE GEORGE'S HYATTSVILLE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, , Funeral Birthplace (State or Foreign Country) 1 M 2 M F 94 217-18-2388 Director Yrs AUGUST 1912 MARYLAND Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-1 shov traumatic event, the Medical Examinar must be notified at Director PRINCE GEORGE'S ty Yes 2 No LANHAM 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 9303 BANDERA STREET 20706 U.S.A. Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. int: if item 27 is marked other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 Yes 2 No 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11TH HOME MAKER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THOMAS Η. BUTLER **EDNA** ADAMS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i JERRY SMITH/SON 9303 BANDERA STREET LANHAM, MARYLAND other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: if it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 11/29/2006 CLINTON MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Lonerar Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Candiovasivan Disease Physician Artenius clienote disease or condition resulting in death) 70915 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death P.O. 1 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 1 ☐ Yes 3 Probably 4 Unknown mclli3v 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

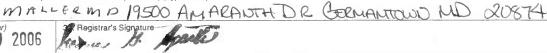
1 ☐ Yes 2 ☒ No has enya certificate 1 Yes 2 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Yes 2 ☐ No this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No i Director: / 2 Accident 3 🗌 Suicide 6 ☐ Could not be in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours after the Funeral Direct 4 Homicide 1) Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Under a transfer of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type ===t) 30. me and address of person Puceusbury Rd Hattsuille MA ORE MIS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 9 2006 Registrar

December 1   December 1   December 2   Dec			1 - For State Registrar	State of N	Marylar				ealth ar D <i>eath</i>	nd Men		ne 0	06	39927
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Sequentially list conditions.    Sequentially list conditions.			shock, or heart failure. List only Immediate Cause (Final disease or condition	aC	erek	val v					piratory arrest			Interval Between Onset and Death
Section   Sect		ner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying	b										
FFEMALE:   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   4   Pregnant at time of death   5   Other (specify)   23d. Date of delivery   Month   Day   Year   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy findings available proposed at the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death?   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy findings available proposed at the underlying cause given in Part I.   25c. Place of Death   Check only one)   25c. Was case referred to medical earning?   25c. Was case referred to medical	f bu, e be execute sician and e burial-trans	cal Exam	that initiated events	c. Due to (or a	as a conseq	uence of):								
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Les Colle College you mo 041794 November 24, 2006  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Physicalla Callakar - you mp 911 Russell Ave Gaithers burg, mp20P76  State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	hysic his ce I direc	2	1 ☐ Yes 2 ☐ No	1 🗆 Inpa		ER/Outpatien		70	4 🗀 140131	ing Home	5 🗌 Residenc	e 6 🗆 Oth	er (Specify	<i>'</i> )
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Les Colle College you mo 041794 November 24, 2006  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Physicalla Callakar - you mp 911 Russell Ave Gaithers burg, mp20P76  State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	LIVIS  Ital or Att  Ital or Att  Ital or Att  Is after de  ai Direct  Ied in by t	Certific	detaminad	286. Place of	njury - At ho etc. <i>(Specif</i>	ome, farm, str y)	eet, factor	y, office					oer or Rura	l Route Number,
Les Colle College you mo 041794 November 24, 2006  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Physicalla Callakar - you mp 911 Russell Ave Gaithers burg, mp20P76  State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	he Hosp in 24 hou he Funei pletely fill	edical	(Greck only 2 Medical Exa	miner: On the basis	ot examina	wiedge, death	occurred restigation	at the tim , in my op	e, date and p einion, death	place, and d occurred at	ue to the caus the time, date	e(s) and ma and place,	anner as st and due to	ated. the cause(s)
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	2	1	30. Name and address of person who	Completed cause o	40 f death (Iten	23a) (Type,	Print)	ОЧ	1794	1	M	ovemb	ser 2	4,2006
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State Registrar 31. Date filed (Month, Day, Year) NOV 2 9 2006

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SAMUEL



Mall

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DO050612

November 27, 2006

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Phy /M Examine

**Funeral** 

Director

with the Maryland show r than "natural", or items 23a or 28a-f shovine Medical Examiner must be notilied at within 72 hours after Health and em 27 is r permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once.

Physician /Medical Examiner

law requires that the death certificate be executed physician a s the burial-t as attending p for use as ed by the a detached f Division of Vital Records. been si has e 2 s rector, page 2

Director: vithin 24 hours

Certificate of Death Reg. No. ecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **JAMES** WALLACE TAYLOR DECEMBER 8, 2006 6:00AM a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BRANDYWINE PRINCE GEORGE'S 10505 CEDARVILLE ROAD, #13-3 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1**X** X 2 □ F DEC.23,1931 VIRGINIA 227-36**-**6366 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 X No MARYLAND PRINCE GEORGE'S BRANDYWINE Direct 10e Street and Number 10g. Citizen of What Country? U.S.A. 10505 CEDARVILLE RD., #13-3 20613 Funeral 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. No 2 □ No If Yes 2 □ No If Yes, Give Year or Dates: KOREA 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: þ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DELIVERY MAN DAIRY COMPANY 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) REV. CLAUDE TAYLOR NORMA CRESS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 10505 CEDARVILLE RD, #13-3, BRANDYWINE, MD JUDITH TAYLOR-SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial XXCremation 3 Removal from State
4 Donation 5 Other (Specify) METROPOLITIAN CREMATORY 12-10-06 ALEXANDRIA, VA MO047922. Name and Address of Facility 21. Signature of Feneral Service Licensee RAYMOND FUNERAL SERVICE, P.A. 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mole of hing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic mimari Masses and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine mylodysplasti Due to (or as a consequence of) Depression Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Oes 3 ☐ Probably 4 ☐Unknown 2 🗆 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 100 1 Tyes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12806 DO057999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JARIWALA, MD 11637 Terrace Prive Ste 103. Waldoxf. MD 20603 MANISHA Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 1 4 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** Elizabeth Voorhaar 2006 Grace December 2:35 p.m. /Medical 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Leonardtown Mary's Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Min. Hours 214-60-3468 Sept. 12, 1907 New York Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiene.

Instit if Hear 27 is marked other than "natural", or Items 23a or 28a-f show my or other transite event, the Medical Examiner must be notified at 1X Yes 2 □ No by Funeral Director Maryland St. Mary's Leonardtown 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 20650 A .

14. Race - American Indian 21585 Peabody Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Stephenson 2 Edward Day 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 543, Great Cacapon, West Virginia 25422 Richard Voorhaar/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or oti 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Ebenezer Cemeterv 12/8/2006 Great Mills, Maryland 21. Si un la service License 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, 22955 Hollywood Road, Leonardtown, MD 20650-0279 M00052 Jr. Approximate Interval Between Opset 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. set and Dea Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a ence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts. Due to (or Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed? 2 **P**No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 P No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Medical Certification: To To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 28a. Date of Injury 28b Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James P 24035 Three Notch Road, Hollywood, Maryland 20636 Jarboe, M.D. 31. Date filed (Month, DEC State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Addie W. Vonmoore NOV 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Çity, Town, or Location of Death 4c. County of Death Examiner edica harles enter If Unde 8. Date of Birth (Month, Day, June 2, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Months Days Hours Min. 93 1913 Kentucky Director 405-05-0359 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Charles Indian Head 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 20640 107 Woodland Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No 21215-0036 Specify Specify: Black δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 Is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) 12 School Teacher State of Kentucky Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Cavette Wilson Reba Ouincey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Woodland Rd., Indian Head, Md. 20640 Effie Thomas Sister permit. Pages 1 an Department of Heal Important: If Item 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Grove Baptist Church Marbury, Maryland 21. Signature of Funeral Service License M00668 Williams Funeral Home, P.A.

4270 Hawthorne Rd., Indian Head, Md. 20640

aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

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Ap 22. Name and Address of Facility 23a. Part1. Enter the distase, or complications that shock, or leart falure. List only one care Immediate Cau e / Inal disease or condition resulting in death) Myocardial Infarction **Physician** HOURS /Medical Due to (or as a consequence of): **Examiner** Years disease arterial Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of): or Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No. 9 Unknown been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? dementia 1 Yes 2 No 3 Probably 4 Nunknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed Yes 2 death? 1 □ Yes certificate 2 No 1∐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this after death.

I Director: After this d in by the funeral di 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely 1 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

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31. Date filed (Month, Day, Year)

JON MOOR

DHMH 17 Rev 1/2001

11350

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sindhwani

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11/26/06

Pembrook Sq. Saite 304 Waldorf, Md. 2003

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Barbara Vest 2339 3, 2006 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton Union Hospitsl Cecil | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1 / 6 / 1 9 3 6 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F 215-32-5149 Yrs Virgínia Director 70 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other then "natural", or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinations of the page 2002. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Harford Edgewood 1 ☐ Yes 2XXNo Funeral Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 205 Flying Point Rd. 21040 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No þ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Nurse 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary E. Burnette Ernest McGuffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina M. Audette (Daughter) 205 Flying Point Rd Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/6/06 A. Ferris & Co. West Chester, PA 22. Name and Address of Facility Tarring—Cargo Funeral Ho Aberdeen, MD 21001–3399 21. Signature of Funeral Service Licenses Home, P.A. WHI) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, physician Certification: To Be Completed by Physician/Medical the signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknows 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 Yes 2 No 4 | Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 1 Yes 2 -NO funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 1 Hipatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No nours after death neral Director: / filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a
To the Funeral C To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 106 5 135653 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elkton, MD 21921 111 W. High St., Suite 104 Martha Hosford, MD speck 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Northaniel MhiTT: Ngton 10:40 A.M 01 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Micomico 516 Village CT
5. Social Security Number 6. SAlisbury If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 **Z**M 2 □ F Days Hours 74 220-28-4400 MD Yrs. 12-28-1931 Director Usual Residence of Decedent permit. Pages 1 and 2 should be fitted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or Iteme 23s or 28s-4 show any injury or other traumatic event, the Madical Examinar must be invitible at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Micomico salisburb 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 516 Villago CI 21801 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1)☑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ENO Specify: þ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mititary Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Whittington Nathaniel IEAGLC ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SALISBURY, NO Sister Greens AD Doris DonohuE 703 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State MD Veterans Comotory 12-8-2006 Hurlock. \* 4 □ Donation 5 □ Other (Specify) P+11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

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Approximate 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a onsequence of): **Physician** 40005 /Medical **Examiner** Hyper Quscon 400c Sequentially list conditions, if any, leading to finite class cause. Enter Underlying Cause (Disease or injury Chia to for as a nonsequence off Examiner The law requires that the death certificate be executed detached for use as the burial-transit disease Hent Can and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician dbe detached for use as the busin Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No DIVOYliculum 24a. Was an this certificate has page 2 autopsy performed? 1 ☐ Yes 2 **2** No or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death after death. I Director: After t Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \text{Homicide} \) within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Do052255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 830 Chesa Cambridge MD E193 Muhammad 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

		For	State of Ma	ryland				nd Mental Hy	giene		
		1 - State Registrar			Cer	tificate of	Death		Reg. No	2006	39934
Physici /Medi		Decedent's Name (First, Middle, L	whit	Le				2. Date of De Month	Day	2006	3. Time of Death 0950M
Examir		4a Facility Name (If not institution, gi	,	HLe	Leiko	4b. City, Town, p	1:-1	Death LY	4c.	County of Death	omico
Funeral Director				(In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24	4 Hrs. 8. Date of Bin (Month, Did 12/23)	ay, Year)	9. Birth	place (State or Foreign Intry) yland
ס		Usual Residence of Decedent  10a, State 10b, County		10c. City, 7	our or los	nation		12/25	1932	. rai	10d. Inside City Limits
Maryla f ehov	ior					ation					12 Yes 2 No
r 286-	Director	MD Wicomi  10e. Street and Number	co	Frul	tland	10f. Zip Code			10g. Citi	zen of What Cou	untry?
th with		244 Sand Castle	Blvd.			21826				USA	
portition of a wild yield within 72 hours after death with the Maryland Department of Health and Mental hygiene. Department of Health and Mental hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28e-f show any Injury or other traumatic event, the Modical Exactions trausal be inclified at a page.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married	If Yes, Give			Vas Decedent of H Yes, specify Cuba	ispanic Origi in, Mexican, Specify:	in? (Specify Yes or No Puerto Rican, etc.)		14. Race - Amer Black, White Specify:	, etc.
ture!	ed b	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's	Year or Dates:		6a. Deced	ent's Usual Occup	ation		16b. Kir	M nd of Business/l	hite ndustry
thin 72	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5-		(Give I	kind of work done of NOT use retired	durina most d	of working			,
led will lygien her th		8	none		Crew	Captain	40.14-4-4	- N			nstruction
d be fil	Be c	17. Father's Name (First, Middle, Las John W. White,						's Name <i>(First, Middle</i> ie White	, Maiden	Sumame)	
2 should and Men ie marke	To	19a. Informant's Name/Relationship	(Type, Print)	1			and Number	or Rural Route Numb	-		
and 2 m 27 I		Lisa Piercy/Dau	ghter			Sand Si	de Est	ate, Deal			
Pages 1		20a. Method of Disposition  1 Agurial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec		cem	etery, crem	atory or other place		Date .2/04/2006		cation - City or T	
permit. P Departme Importan any Injury		21. Signature of Funeral Service Lice		St.		Cemeter Name and Addres nman Fun			weno	ma, Mar	yland
Depa Impo		ARLO F VIER	may M	00295				ome ve, Prince	ess A	nne, MD	21853
		23a. Part1. Enter the disease, or con shock, or heart failure. List onl	mplications that caused to y one cause on each line	the death. e.	Do not ente	or the mode of dyin	g, such as ca	ardiac or respiratory a	ırrest,		Approximate Interval Between Onset and Death
Physician /Medical	0	Immediate Cause (Final disease or condition resulting in death)	a. Meta	static	co off:	lung	Cen	de			
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scuted ind transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	Due to (or as a								
cate be executed only sicien and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a	consequer	nce of):						
certific nding p	/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnance	y					23d. Date of deliv	/AN/
w requires that the death certific been signed by the attending p should be detached for use as	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 Fetal de	ath 3 🗌	Ectopic pregnancy Other (specify)				Month	Day Year
that the		9 ☐ Unknown  Part II. Other significant conditions		t not resultir	ng in the un	deriving cause giv	en in Part I	23e. Did	tobacco u	se contribute to	the cause of death?
duires t quires t n signe	d by				ig in the dir	delly and cause giv	on in rain.		/		bably 4 Unknown
aw rec	Completed							24a. Was		24b. Were aut	opsy findings available ompletion of cause of
The cete he	Com							auto perfe	2/2 No	death?	2D No
v tv. sician certifi rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes  No	Hospital	0.50		20 DOA Oth	0.00	of Death (Check only			
g Phys	n: To	27. Manner of Death	28a. Date of Injun (Month, Day	v 28	Outpatient	3 DOA 28c. Injun	4   Nurs	sing Home 5 Resi			ify)
endin eath. or: Aft	atlo	Natural 5 Pending investigation	on	7 60.17	Injury		Yes 2 □ N	0			
To the Hoepital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificete hes been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home . <i>(Specify)</i>	e, farm, stre	eet, factory, office		28f. Location ( City or To	Street and wn, State)	d Number or Rui )	ral Route Number,
n 24 hou n 24 hou e Funer bletely fill	edical	29a. Certifier 1 Certifying F (Check only 2 Medical Example)	Physician: To the best of aminer: On the basis of and manner state	examination	dge, death and/or inv	occurred at the tin estigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
To t withi To t	Σ	29b. Signature and title of certifier	00	)n	D	29c. Licens	number	78		e signed (Month)	
		30. Name and address of person who	completed cause of de	stal H	Ba) (Type, F		80× 1	733 Sa	lest-	MD	21862
Sta Regist		31. Date liled (Month, Day, Year)	32. Registra	r's Signatur	9 /	1			(	y	-
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								Cer	titica	te of	Death	1		Reg. No.			
			1. Decedent's Name (First, Mide	dle, Last)									2. Date of De	eath Day	Year	3. Tim	ne of Death
	Physici				Mary	Isabel	lle Winte	ers					Dece	mber 04, 20	006	6:5	55 A.M.
1	/Medic Examir		4a. Facility Name (If not institution	on, give s							4b. City, To	wn, or L	ocation of Deat	h 4c. Count	y of Death		
+	Examin	ier	· ·				20				ī	onacc	ning		Alleg	anv	
			5. Social Security Number	6. Sex	Nursing	-	(In yrs. last	hirthday)	If Unde	r 1 Yea			8 Date of Bir	th	9 Birthpla	ace /Sta	ate or Foreign
	Funeral				M 22 F	7.7.gc	93	Yrs.	Months			Min.	(Month, Da	iy, Yea <i>r)</i> er 23, 1913	Count	Yaryl	and
	Director		213-22-4327 Usual Residence of Decedent			į	93	ļ	<u></u>				Septembe	1 23, 1913		141 ) 1	
	pu ≱ _		10a. State 10b. Count	īv		I	10c. City, To	own or Lo	cation					<del></del>	10	d. Insid	le City Limits
	sho	<u>&gt;</u>					•				I	:~					Yes 2 □ No
	86 M	ğ	Maryland	Alleg	any						Lonaco	ming					
	₹ 2 ±	Director	10e. Street and Number						10f. Zi	p Code				10g. Citizen of		-	
	23e	<u>a</u>	57	Jacks	son Stre	et					2153	19			U.S.A	١.	
	eep E	Funeral	11. Marital Status		12. Was De Armed F	cedent E	ver in U,S.	13. \	Was Dece	dent of	Hispanic Or	igin? (Sp	ecify Yes or No Rican, etc.)	- 14. Ra	ce - America ick, White, e		n,
0	afte or it	Ē	1 ☐ Never Married 2 ☐ Ma		1 ☐ Yes If Yes, G	2 <b>X</b> N	0	}	1 □ Yes				,	Specia			
8	ours Bei',	δ	3 XWidowed 4 ☐ Divorce	ed	Year or	Dates:				-54	opcony.			Opecin	y.	Wh	ite
9	be filed within 72 hours after death with the Marylend tal Hygiene. d other then "natural", or items 23e or 28e-f show event, the Medical Examinar must be redified at	Completed	15. Decede (Specify only high	nt's Edu	cation	n	16	Sa. Deced	dent's Usu	al Occu	pation during mos	et of work	rina	16b. Kind of B	Business/Indu	ustry	
7	E . E	를	Elementary/Secondary (0-12)		College		+)	life. L	DONOT	se retir	ed)	or or work	wig				
7	the lien	E 0	9			0	''				Labore	r			Texti	ile	
o	ent,	0	17. Father's Name (First, Middle	e, Last)							18. Moth	er's Nam	e (First, Middle	, Maiden Surnai	me)		
ᄪ	d be ental red c	o Be		(	George I	Dalev							Mar	y Ann Mc	Ginty		
<u>&gt;</u>	d Me d Me mark	P	19a. Informant's Name/Relation			July	1	9h Mailin	na Addres	s (Stree	et and Numb	er or Ru		er, City or Town		Code)	
<u>8</u>	32s han risi traul	8	George V				1	OD. HIGH	•					ing, Maryl			
a)	l and dealt		20a. Method of Disposition	/V IIILEI	3 - 3011		20b. Place	of Disno			St Widin	Street	Date	20c. Location			
ō	permit. Pages I and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f show eny injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation	3 □R	emoval from	1 State	ceme	tery, cren	natory or	other pl		1	December				
<u>≅</u> .			4 ☐ Donation 5 ☐ Other (	Specify)				Sunset	t Mem	orial	Park	1	08, 2006	Cum	berland,	Mary	/land
Baltimore, Maryland 21215-0020	permit. Departimoports imports eny inj once.		21. Signature of Funeral Service	e License	e.			22	. Name a	nd Add	ress of Facili	ity orn-M	cKenzie F	uneral Hor	ne P.A.		
m	89 = 99	1	1 5. Mi	Kan	11									aconing, M		9	
		_	23a. Fa. (1. Enter the disease,	or compli	cations that	caused	the death. D	o not ent	er the mo							Approxi	imate
	Dhusisian	9 D	ock, or heart failure. Lis	st only or	ne cause on	each lin	e.								1	Interval Onset a	Between and Death
)	Physician / /Medical		Immediate Cause (Final			_	11/			. 4		_		10	į	,	
	Examiner		disease or condition resulting in death)	а	ı	101	VCES Due to (or as	TIV	E	1/2	120	1-	Alle	45	ago	M	1 is year
		7				1	Due to (or as	a conseq	uence of)	i in		i en	10	EATH	1		
	ed sit	듣		_ b	).	C	MON	1178	4	1	1 28	4	10151	けていた	cett	74	10 year
	and and I-trar	Xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				Due to (or as	a conseq	uence of)	:		,					9
ox 68760,	be e cian buria	=	cause. Enter Underlying Cause (Disease or injury	Z,	)												
8	certificate be executed nding physician and use as the burial-transit	n/Medical Examiner	that initiated events resulting in death) Last	1			Due to (or as	a conseq	uence of)						İ		
9 ×	ing ing	Įĕ.		L.	1										•		
	attenc I for us	a													I		
<u>.</u>	e de the a	Sic	Part II. Other significent condit	tions con	tributing to	death bu	t not resulting	g in the ur	nderlying	cause g	iven in Part	l.	23b. Did	tobecco use co	ontribute to	the ceu	ise of death?
P.O. B	The law requires that the death ate has been signed by the atte page 2 should be detached for	Physicia	Carl.		1	14	esh	15					10	Yes 2□ No	3 🗌 Probe	abiy	4 Unknown
σ	as th gned be d	ğ	Cardi	an)	0	1	//	7001	you	2							[
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₹	ysician: is certific director,	8	25. Was case referred to medic examiner?		lospital: ,					0	thor		th (Check only				
o	2 00	P	1 ☐ Yes 2 No 27. Manner of Death		28a. Date		nt 2□ER/	Outpatien		OA	1000	ursing Ho		dence 6 🗆 Ot how injury occu			
Ξ	in the second	ō	1 Natural 5 □ Pend		(Mo	nth, Day	Year)	Injury	м	28c. Inje	ork? □Yes 2□	l Nio	Zod. Dosonbo	now injury coou	ii Cu		
Division of Vital Records,	Attending ir death. ector: After by the fune	CertIfication:	2 Accident inves 3 Suicide 6 Could	tigation d not be								INO	Opf Laastian (	Cton and a small fill com	ha a a a Direct	Dougla	A le com form or
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	tal of is eld is led is	Ö															
	ospi hou uner uner	edical												cause(s) and m date and place			ise(s)
	To the Hospital or Attending Phy within 24 hours efter death. To the Funeral Director: After thi completely filled ir by the funeral		one)			nner sta											
	Vith Total	Σ	29b. Signature and title of certif	ier	,				29	c. Licer	nse number			29d. Date sign	ed (Month, D	ay, Yea	ar)
				7	Truil	u				02	690	7		DECEI	UBER	- 5	2006
			30. Name,and address of perso	n who co	mpleted_cau	use of de	eath (Item 23a	a) (Type,	Print)	1			4	1		1	1
		4	HARSIT S		Sidh		nD.	725	Set	in l	Drive	(	umberla	DECEN	morlin	nd	21502
	Sta	ite	31. Date filed (Month, Day, Yea				r's Signature				1				-		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Wolfe Geraldine 29 2006 NOVEMBER 22:21 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 31, 1930 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 214-32-3488 76 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Allegany Westernport 1XiYes 2 ☐ No MD. ? Is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical Examiner must be notified Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 118 Kolberg Drive SW 21562 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐ Yes XXX No white Specify: ģ Specify: 3.⊟Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hospital Elementary/Secondary (0-12) College (1-4or 5+) Custodian unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental I Grover Bosley Viola Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health s Important: If item 27 Is any injury or other tra Daniel T. Wolfe SR/ son P.O. Box 66, Pinto, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State /30. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Cumberland Maryland Cumberland Crematory 2006 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee a 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death WEEK Immediate Cause (Final Physician RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEIZURE CHRONIC OBSTRUCTIVE PULMONARY DISEASE MANY YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death detached Division or Vital Records, P.O. 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DEEP VENOUS THROMBOSIS WITH PULMONARY EMBOLISM, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No CERBRAL VASCULAR ACCIDENT, OBSTRUCTIVE SLEEP APNEA 24a. Was an page 2 s autopsy certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ဥ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred spital or Attending P nours after death. ineral Director: After y filled in by the funer After 1 Certification: 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal

within 24 hours a To the Funeral L Hospital

(Check on one) and manner stated. 29b. Signatu

29c. License number

D18216

29d. Date signed (Month, Day, Year) 06

and address of person who completed cause of death (Item 23a) (Type, Print)

SMITH, STEVEN R., M.D., 900 SETON DRIVE, CUMBERLAND, MD 21502

State Registrar

		-	For State Registrar	State of Maryla		artment of H			ene 0 0	6	39937
j.ir	8 8 3°	_	Decedent's Name (First, Middle, Last)					2. Date of Deatl	1	Vane	3. Time of Death
	Physicia /Medic		Adele Catheri	ne Johnson V	Varneck	е		November	29, 20	906	10:45 P.M
	Examin	_	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of De	ath	4c. County	of Death	
***			Wilson Care Center			Gaither			Montg		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours M	in. (Month, Day,	Year)	Count	
96	Director	-	077-16-9728 Usual Residence of Decedent	- 07	113.			May 26	, 1919	New_	York
	land ow		10a. State 10b. County	10c. C	City, Town or Lo	cation				10	d. Inside City Limits
	Many I-f sh	tor	Maryland Montgome	ery			Layt	onsville			1 ☐ Yes 2X No
	h the	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Count	iry?
	th wit	aiD	8807 Primula Drive			20882			U.S.A.		
	ems erms	ner	11. Marital Status	<ol><li>Was Decedent Ever in Armed Forces?</li></ol>	U.S. 13.	Was Decedent of H	ispanic Origin? in, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		- America k, White, e	
36	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ② Widowed 4 ☐ Divorced	1 □Yes 2 🛣 No If Yes, Give		1 ☐ Yes 2 X No	Specify:		Specify.	Whit	:e
21215-0036	hour ture!	q pa	15. Decedent's Educ	Year or Dates:	16a Dece	dent's Usual Dccup	ation		16b. Kind of Bu		
<u>.</u>	in 72 in na	piet	(Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	during most of v	vorking			,
77	with liene.	шо	Elementary/Secondary (0-12)	College (1-4or 5+) 2	Hom	emaker			Own H	ome	
פ	othe vent,	0	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle, A	Maiden Surnam	в)	
/lar	Venta Menta rrked	To B	Harold Phillip John	ison				n A. Nordh			
Maryland	2 sho and I s ma	8 4	19a. Informant's Name/Relationship (Type					Rural Route Number,			
≥.	and ealth m 27		Susan W. Johnson /					Laytonsvil		-	
ore	ges 1 I of H If ite		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ R			osition (Name of matory or other place		13	20c. Location -	•	
altimore,	tmen tant:		4 □Donation 5 □ Other (Specify)					12/01/06	Alexa	ndria	, Virginia
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show emportant: If item 27 is marked other then "naturel", or items 23a or 28a-f show emportant: If item was a naturel in a naturel in a naturel in a naturel in a naturel in a naturel in a naturely or other traumatic event, the Medical Exeminer must be notified an once.		21. Signature of Funeral Service License	m. Holl		26401 Rid	h-Willi ge Road	ams P.A., Damascı	ıs, Mar	l Hom yland	20872
4			23a. Part1. Enter the disease, or compli shock, or heart failure. List only on	cations that caused the de e cause on each line.	ath. Do not en	er the mode of dyin	ig, such as card	liac or respiratory arre	est,		Approximate Interval Between Onset and Death
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4	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):						
*		<u>.</u>	Sequentially list conditions,	Ope to (or se a cone	chiasta di						
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		9001100 017.						
	ayecu al-tra	хаг	that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
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9	ifficat g phy as the	edic									
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		sicia	in the past 12 months? 1  Yes 2 No	4 Pregnant at time of		Other (specify)			Mor	nth	Day Year
P.0.	by tac	hy	9 Unknown								
Vital Records, I	es pe	þ	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	inderlying cause giv	en in Part I.			3 Proba	e cause of death? ably 4 Junknown
CO	> 0 70	Completed						24a. Was a	24b. V	Vere autor	osy findings available
Re	The age	E						<ul><li>autops perform</li><li>1 ☐ Yes 2</li></ul>	ned o	leath?	npletion of cause of 2 No
ita	lcian: T	0	25. Was case referrent to medical				26. Place of [	Death (Check only on			
<b>1</b>	d is	To B	examiner? 1 Yes 2 No	lospital: 1 🗌 Inpatient 2	☐ ER/Outpatie	nt 3□ DOA Oth	er: 4 Nursin	g Home 5 🗆 Reside	nce 6 Othe	er (Specify	)
n of		ation:	27. Man or of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur Wor	y at k?	28d. Describe ho	w injury occurr	ed	
Sio	at sat	cati	2 Accident investigation				Yes 2□No				- 19
Division	or Attendated after death	Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st cify)	reet, factory, office		28f. Location (St. City or Town		er or Rurai	l Route Number,
	Hospital 24 hours a Funeral C		29a, Certifier 1 Certifying Phys	sician: To the best of my k	nowledge deal	h occurred at the tir	me date and ni	ace, and due to the or	use(s) and ma	nner as st	atad
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical		ner: On the basis of exami and manner stated.		vestigation, in my o	pinion, death o	ccurred at the time, da	ate and place, a	and due to	the cause(s)
	To the To the Complex	Σ	29b. Signature and title dicertifier	08		29c. Licens		_	9d. Date signed		
			1 1 1	, I John			2014	0	novem	hg.	30,2006
(	7		30. Name and address of person in co	liniky	111 R	ussell 1	fre,	Gaithersk	one w	1d.	
	Sta Regist		31. Date filed (Month, Day, Year) DEC 0 1 20	32. Jegistrar's Sig	nature (	barte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Josephine Whitmore /Medical 28 2006 Vovember 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Salisbury Wicomico 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year, 8/30/1930 9. Birthplace (State or Foreign Country) New York Months 1 ☐ M 2 📉 F 131-22-4522 Hours 76 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Delaware Sussex Georgetown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Nancy St. Be Completed by Funeral 19947 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 월 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced Specify white 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Home Goods 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Ciaramella Rose Marano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Whitmore/husband 301 Nancy St., Georgetown, DE 19947 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State 4 Donation 5 Other (Specify McCracken Funeral Home 11/30/06 Union, NJ 22. Name and Address of Facility

22. Name and Address of Facility

House Professional Association

501 Snow Hill Rd., Salisbury, MD 21804 re of Funeral Service L art 1. Enter the disease, or complications that caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus are each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetel death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes → No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

**Funeral** 

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or fleme 23a or 28a-f ehow any highry or other fraumatic event, the Medical Examinat must be notified at once.

Baltimore, Maryland

Examiner attending physicien and for use as the burial-transit Physician/Medical is been signed by the should be detached Completed by To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific, completely filled in by the funeral director. 2 Certification;

Division of Vital Records, P.O. Box 68760

1 Tes 2 No

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide

Hospital: 1 \_\_\_\_\_atient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number. City or Town, State)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. am and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

31. Date filed (Month, Day, Year) NOV 3 0 2006

6

106 32. Registrar's Signature

7.76-1 St 5-100 10 7 184

			For State Registrar	State of Marylan		artment of		and Mental Hy	giene	16 39939
0	Physici		1. Decedent's Name (First, Middle, Las		am			2. Date of De Month	ath	3. Time of Death 7:00 AM
0.	/Medio Examir		4a. Facility Name (If not institution, give	street and number)	(0000	/	n, or Location o		4c. County PRINC	
*	Funeral Director		215-88-4101	ex	ast birthday) Yrs.	If Under 1 Ye Months Da		Min. 8. Date of Bit (Month, Date of Bit (Month, Date of Bit (Month, Date of Bit (Month), Date	ay, Year)	9. Birthplace (State or Foreign Country) TRINIDAD
re, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  MD PRINCE 0  10e. Street and Number  4202 58th AVENUE  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  (Specify only highest grave)  Elementary/Secondary (0-12)  12th  17. Father's Name (First, Middle, Last)  DAVID MCMU  19a. Informant's Name/Relationship (1)  SANDRA GREENHILL/  20a. Method of Disposition	IZ. Was Decedent Ever in U. Armed Forces?  1	S. 13. 1  16a. Deced (Give lifte.  PRIVA  19b. Mailir  9731 lace of Dispo	ENSBURG  10f. Zip Cod  2071  Was Decedent of Yes, specify Cod  1 Yes XIII  dent's Usual Occurrence of Work do NOT use related to the Code of Yes and ATE DUTY  and Address (Street GOODLUC)  isstition (Name of	Of Hispanic Original Cuban, Mexican, Mexican, Mexican, Mexican, No Specify:  cupation and during most tired)  7 NURSE  18. Mother ADIN  eet and Number CK ROAD	r's Name ( <i>First, Middl</i> e	PRIVA , Maiden Sumanner, City or Town, RYLAND	e - American Indian, ik, White, etc.  BLACK usiness/Industry  ATE   Pel  State, Zip Code)
Baltimore	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trau <u>once.</u>		1 Paurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	FT.	LINCOL 22	natory or other to the control of th	ERY I		BRENTWOO	DD, MARYLAND NERAL HOME
8760,	Physician /Medical Examiner physician and physician and the prival-transit	dical Examiner	23a. Part1. Enter the disease, or companies, hock, or heart failure. List only of the case of condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of the death one cause on each line)  a. Due to (or as a consequence of the death one cause on each line)  Due to (or as a consequence of the death one cause on each line)  Due to (or as a consequence of the death one cause of the death one cau	uence of): button uence of): Long	er the mode of a	dying, such as of	ardiac or respiratory a		Approximate Interval Between Onset and Death
P.O. Box 68	the death certifu by the attending p ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregna Other (specify,			23d. Dat Mor	e of delivery nth Day Year
of Vital Records, P	e law requires that has been signed k je 2 should be det	Completed by P	Part II. Other significant conditions co	ontributing to death burnot resu	ulting in the u	nderlying cause	given in Part I.	23e. Did l	Yes 2 No	ribute to the cause of death?  3 Probably 4 Unknown  Were autopsy findings available prior to completion of cause of
ital R		Be Con	25. Was case referred to medical examiner?				26. Place	perfo 1 ☐ Yes of Death (Check only o	ormed? c	leath? ☐ Yes 2☐ No
Division of V	ding Phys h. After this funeral dii	Certification: To I	27. Manner of Death  1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Ir	njury at Vork? Yes 2 \( \int \)	28d. Øescribe	dence 6 Other	ed
Div	in Signal		4  Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	")			City or To	wn, State)	er or Rural Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)  2	vsician: To the best of my know iner: On the basis of examinat and manner stated.	ion and/or inv	vestigation, in m	e time, date and ly opinion, deatl	a piace, and due to the hoccurred at the time,	date and place, a	nner as stated. and due to the cause(s)
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_	(1)		ELLOSA S. HOLLA		05 L	Print)	o Ro	Ste 3 C	HEREXC	4, Md 20185
	Sta Registr	-	31. Date filed (Month, Day, Year) NOV 2 8 2006	32. Registrar's Signat	boeils					,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 3994 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Richard W. Wilson November 28, 2006 9:30 PM /Medical 4a. Facility Name (If not institution, give street end number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year Jan. 8, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 X M 2 □ F 84 1922 **Director** 340**-**18-1209 Iowa Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygleine. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19109 Rhodes Way 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White ģ 3 ☐ Widowed 4 MDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Writer Journalism 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Wilson Fern (unobtainable) ၉ 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Stern / Partner 19109 Rhodes Way, Montgomery Village, MD 20886 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. Date 0, 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Resthaven Crematory 2006 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the disease shock, or heart failure. , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is only one cause on each line. Immediate Cause (Final **Physician** Liver Metastases disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Colon Cascinoma 6 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, \$ Malignant Ascites 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Peritoneal Carcinomatosis autopsy performed? 2XX No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 X Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Medical Certification: Division Fo the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident neral Director: , filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

State Registrar

31. Date filed (Monti

Juvenal Goicocheo,

29b. Signature end titl

M.D. 8218 Wisconsin Ave., Ste. 212, Bethesda, MD 20814 strar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MU

29c. License number

22450

29d. Date signed (Month, Day, Year)

Nov. 29, 2006

		•	1 - For State Registrar	te of Maryland	•	irtment of He tificate of D			giene2	006	399	942
ly .	4 TO 10	*	Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of	Death
	Physicia /Medic		Jeanne M. Walter					Novembe	er 23	2006	8:45	Рм
	Examin	_	4a. Facility Name (If not institution, give street a	nd number)		4b. City, Town, or	Location of Death	1		nty of Death		
			Anne Arundel Medical ( 5. Social Security Number 6. Sex	Center 7. Age (In yrs. la	at hinth day.	Annapolis	If Under 24 Hrs.	8. Date of Bir	+h	e Arui	ndel lace (State or	Foreign
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4	Director		063-20-8053 Usual Residence of Decedent	1.5				10/11/		11.011		
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е Ма	Ba-f e	Director	Maryland Anne Arundel	Anna	polis						1 🗌 Yes	2 <b>X</b> 1140
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hin 7	Mad "	Completed	(Specify only highest grade comp Elementary/Secondary (0-12) Col	lege (1-4or 5+)		kind of work done di OO NOT use retired)		King				
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d 2 st	th and		Richard S. Walter, Sr			Alfred Ci			•			
1 and	Heal tem 2 other		20a. Method of Disposition	20b. Pla	ace of Dispos	sition (Name of		Date	20c. Locatio			
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permit. F	Department of Health a important: if item 27 is only injury or other training.		21. Signature Sylvheyai Service Licensee			. Name and Address						
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*:			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death.	Do not ente				rrest,		Approximate Interval Betw	veen
Ph	ysician		Immediate Cause (Final disease or condition	metar	tal	Can	ance	1			Onset and D	eath
	Medical kaminer		resulting in death)	ue to (or ae/a consequi	ence of):	0.						
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hysic	his ce I direc	10	examiner? 1 Yes 2 No Hospita	1 Minpatient 2 Lit	R/Outpatien		4 Nursing H	lome 5 ☐ Resi	dence 6 🗆	Other (Specia	(y)	
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Itend	death stor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	Place of Injury - At hor	ne farm str		es 2 □No	28f. Location (	Street and Nu	mber or Rus	i Boute Num!	her
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DIVISION OF VITAL MECONICS, F.C. BOX 00/00, To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physician:									
e Ho	in 24 he Fu oletely	edical	(Check only 2 Medical Examiner: One)	n the basis of examinati d manner stated.	on and/or inv	estigation, in my op	oinion, death occu	irred at the time,				
Tot	To t	Σ	29b. Signature and title of certifier	1		29c. License		13/	29d. Date sig			
			· curs U	ann	m	0 0	5 5 3 6	10		1/24	106	
	4.		30. Name and address of person who complete	d cause of death (Item	23a) (Type,	Print) D	P300	Anna.	10/10	in in	1 211	1
(18th	Sta	ato.	31. Date filed (Month, Day, Year)	2. Registrar's Signati		NU 1	. , , ,	1111101	0//3	07/2	-17	6.1
	Registi		NOV 2 7 2006	Color A	Mach	Se o						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiené 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year **Physician** oodstoc Ам 24, 2006 7:35 November /Medical 4a. Facility Name ( not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Queen Anne's Corsica Hills Nursing Home Centreville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthdav) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 ☐ M 2 ☑ F 90 111-01-8924 Director June 22. 1916 New York Usual Residence of Decedent the Maryland 10c. City. Town or Location 10h County 10d. Inside City Limits 10a State 28a-f show traumatic evant, the Madical Examiner must be notified at Centreville Maryland Queen Anne's 1 Yes 2XXV Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 114 Price Street 21617 U.S.A. or Itams 23a death Completed by Funeral Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or Ital 1 Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes **2**CXNo Specify: Specify: White 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Transcriptionist Hospital 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Helen Dietz Frank Marks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is rr any injury or othar traum <u>once.</u> Elizabeth Hanbury/daughter 114 Price Street Centreville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11/28/2006 4 ☐ Donation 5 ☐ Other (Specify) Hillerest Mem. Gardens Annapolis, Maryland 21. Signatu Frineral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician drate disease or condition resulting in death) /Medical ue l (or as consequence of): Examiner Hermer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or lighty that initiated events Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □Fetal death 23d. Date of delivery 23b. Waş decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Yes 2 No 3 Probably Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has 20 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Hospital or Attanding PI
 A hours after death.
 Funaral Director: After the 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural N 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 1 ac 30. Name and address of person who completed caus e of death (Item 23a) (Type, Print) Nayne D , V

State Registrar

31. Date filed (Month, Day, Year)

32. Begistr

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 39944 State of Maryland / Department of Health and Mental Hygiene [] [] [5] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 23, 2006 11:30 a M Madelyn Elizabeth Wade Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Mar. 15, 1 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 ☐ M 2 💢 F 91 Yrs. Director 225-18-5113 Mar. 1915 VA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f eho other traumatic event, the Medical Expension must be notified at VA Shen Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 412 2nd Street 22849 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Dental Assistant Dentist Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental ! Doc Comer Zettie Hamm ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Geraldine Clark/Daughter 186 Topeg Drive, Severna Park, MD 21146 Nov. 28, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State Department of Important: If any injury or once. Shanandoah, VA 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 2006 Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician reeks Oneumaria disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting to the cause of the c Due to (or as a consequence of) Examiner use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical SE FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. After this certificate has been signed by the inneral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy perform 2 No 25. Was case referred to medical 26. Place of Death |Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 -Natural 5 Pending death. after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral ( Medical 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 051819

DHMH 17 Rev 1/2001

Registrar

132 Holidan

32. Segistrar's Signature

CT sate ear Annualis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, the has this after death. filled in by

Baltimore, Maryland 21215-0036

Certification: To 28c. Injury at Work? Injury (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) NOV 29

2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Anuradha Arun, M.D. 10301 Georg 10301 Georgia Ave, #209, Silver Spring,MD 32 Registrar's Signature

Cun, M.D

To the Hospital within 24 hours a To the Funeral Completely filled in the Funeral Completely filled

D0057630

11/24/06

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Gene William Wen		otato of marylana, population of reduction	id Mental I	Hygiene	000	c 0001				
	Б	-For State Certificate of Death  1. Decedent's Name (First, Middle, Last)		2. Date of De	Reg. No. 200	3. Time of Death				
Physician/ Medical Examine		Gene William Wenzel		Month	Day Year er 25, 2006	0159 hrs				
	ŀ	4a Facility Name (if not institution, give street and number)  4b. City, Town, o			4c. County of Deat	h				
	Ł	13107 Briarcliff Terrace # 208 Germantov			Montgomery					
Funeral Director	ŀ	5 Social Security Number 6-Sex 7, Age (In yrs, last birthday) If Undec 1. Yei  215 - 78 - 4705 1 XM 2 F 48 Yrs.		in. 8. Date of B	Forth	rthplace (State or <b>ashington</b>				
Directo.	H	215-78-4705   1XM 2 F   48 Yrs.   World's Bay		pec.	17, 1957	D. C.				
any	- 1-	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits				
and fshow	; L	MD Montgomery				1 X Yes 2 No				
the Maryland or 28a-f sho ifical at once		10e, Street and Number 10f, Zip Code	)874		10g. Citizen of What Cou	intry?				
ith the Maryland 23a or 28a-f show a motified at once. al Director		13107 Briarcliff Terrace 20		Specify Yes or N	USA	ican Indian, Black,				
or items 23 or items 23 must be no Funeral		1 Never Married 2 Married Armed Forces? If Yes, specify Cuba			White, etc.					
after or all', or iner n		3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No				hite				
5-0036 ed within 72 hours aft tygiene. Nother than "natural" he Medical Examine Completed by	}	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	ation (Give kind o e. DO NOT use r	f work done etired)	16b. Kind of Business	'Industry				
336 hin 72 te. than than		12 laborer			constru	ction				
5-0036 Hygiene. John Hamedical		17. Father's Name (First, Middle, Last)			, Maiden Surname)					
2121: buld be fill Mental H marked c event,		Clyde Wenzel  19a Informant's Name/Relationship (Type, Print )  19b Mailing Address (Stre		Smith	mbos City as Town State	2176				
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Itant: If iten 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		JoAnn Mattheis (Sister) 110 North	Pointe	Terra	ce, Middle	town, MD				
e, N L and S Health Titem	Ī	20a. Method of Disposition  20b. Place of Disposition (Name of ce crematory or other place)	emetery,	Date	20c. Location - City of	Town, State				
Baltimore, pernit. Pages I an Department of Hea important. If iter		Lutheran Ceme	tery 1	1/29/06	$\delta$ Middleto	wn, MD				
Baltimo permit. Page: Department o Imy-rant: ingur or oth		Signature of Funcial Cervice Licensee 22 Name and Address Donal C	s of Figure	oson Fu	uneral Hom	e				
Physician	4	P. O. BO 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying	X 10, 1	niaarei	cown, MD 2	1/69 Approximate Interval				
/Medical		failure. List only one chuse on each line.  Immediate Cause (Final difease a Intraoral gunshot wound				Between Onset and Death				
Examiner		or condition resulting in death)  Due to (or as a consequence or)								
10	,	Sequentially list conditions, if any, leading to immediate   Due to (or as a consequence of):		<u> </u>						
ed la la la la la la la la la la la la la		cause. Enter Underlying Cause (Disease or injury that initiated								
ecuted and transit		events resulting in death) Last  Due to (or as a consequence of):  d.								
00,  E. be executed spician and burial - transited burial - transited ledical E)		X UNPENDED #23a,27,28a-f, perME, g862.	12/16/06	, TT						
68760, certificate b nding physises as the but	FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 25b. Was decedent pregnant in the 25b. Was decedent pregnancy 25b. Was decedent predicated pregnancy 25b. Was decedent pregnancy 25b. Was decedent p									
box 6876.  The death certificate the attending phy op the attending phyched for use as the Physician/M		past 12 months?  4 Pregnant at time of death 5 Other (Specify)	Ectopic preg	nancy	Month	Day Year				
Box le death c the atten ted for us		1 Yes 2 No 9 Unknown 9 Unknown		Too and						
tal Records, P.O. Box 6876 crian: The law requires that the death certificate certificate bas been signed by the attending physector, page 2 should be detached for use as the Be Completed by Physician/M		Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.		tobacco use contribute to					
Records, The law requires ficate has been sign page 2 should be Completed	3			24a. Wa		utopsy findings available				
cor e law r e has b ge 2 sh					formed? death?	completion of cause of				
I Re n: Th rtificat or, pag		25 Was case referred to medical 26.Plac	e of Death (Chec	1 Yes	2 No 1 Y	es 2 No				
Division of Vital Records, tal or Attending Physician: The law requirers after death all Director: After this certificate has been sited in by the funeral director, page 2 should be riffication: To Be Completed	١٠	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other Nur	sing Home 5	Residence 6 🗸 Othe	er: Scene				
n of V ding Phys a After thii funeral di		(Month, Day, Year)	ury at Work? Yes 2 V No	28d Describe	how injury occurred					
IVISION or Attend after death Director: I in by the I	3	shot self (Street and Number or R	ural Route Number. City							
Division o sepital or Attending hours after death nearal Director: Aft y filled in by the fund Certification:	5	3 X Suicide 6 Could not be determined (Specify) residence			State) 13107 Brian					
To the Hos within 24 h To the Fin completely		and manner stated	n, death occurred	at the time, dat						
2	-		.M.E.		November 26, 2					
	-	30. Name and address of person who completed cause of death (Item 23a)								
		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltim	nore, MD 212	201						
State Registra	e	31. Date filed (Mexical Pay Year) 2006 33 Registrar's Signature								
		AV - A								

			For State Registrar	State of Ma		artment of Healt rtificate of Dea		lygiene Reg. No. 2 (	006 3991
X	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, PATRI 4a. Facility Name (If not institution,	CIA give street and number)	WINEB	RENNER  4b. City, Town, or Locat	ion of Death	ber 6, 2	y of Death
E <sub>2</sub>	Funeral Director		Memorial Hospit  5. Social Security Number  220-40-1463  Usual Residence of Decedent	5. Sex 7. Age	e (In yrs. last birthday)  63  Yrs.	Cumberland  If Under 1 Year   If Ur  Months   Days   Hou	nder 24 Hrs. 8. Date of	Dav. Year)	9. Birthplace (State or Ford Country)
	death with the Maryland ms 23a or 28a-f show r must be notified at	Director	10a. State 10b. County Alle	gany	10c. City, Town or Lo	nberland		10g. Citizen of	10d. Inside City Lin 1 Yes 2
	ter death with t Items 23a or 2 ner must be n	Funeral Dir	724 Oldtown Ro  11. Marital Status	12. Was Decedent E	Ever in U.S. 13.	10f. Zip Code  21  Was Decedent of Hispanie If Yes, specify Cuban, Me	502 c Origin? (Specify Yes or	<u> </u>	JSA ce - American Indian, tck, White, etc.
-0036	72 hours after de natural", or Item Ilcal Examiner r	þ	1 Never Married Married 3 Widowed 4 Divorced  15. Decedent's	d 1 ☐ Yes 2 🔏 N If Yes, Give Year or Dates:	No 16a Dece	1 ☐ Yes 2 ☐ Xio Spe	cify:	Specia	
3 21215	within 7 iene.  than "r	Completed	(Specify only highest Elementary/Secondary (0-12)  12 17. Father's Name (First, Middle, Lit	College (1-4or 5	+)	kind of work done during DO NOT use retired)  nistrator	most of working  Name (First, Midd		st Memorial Pk
Maryland 21215-0036	s 1 and 2 should be filed f Health and Mental Hyg ftem 27 is marked other other traumatic event,	To Be	James K. Ko	erner p (Type. Print)		ng Address (Street and No	Margaret Ko	perner	n, State, Zip Code)
Baltimore, N	Page ent o nt: If i	j.	Allen Winebren  20a. Method of Disposition  1 Deurial 2 Cremation 3  4 Donation 5 Other (Spe	3 □Removal from State	20b. Place of Dispo cemetery, cre	4 Oldtown Ro sition (Name of matory or other place) emorial Park	Date 12/11/20		MD 21502 - City or Town, State Derland MD
Baltin	permit. Pa Departmer Important: any injury once.		21. Signature of Funeral Service Li	censee D	pelli 2	2. Name and Address of F Scarpelli Fu 108 Virginia	Avenue: Cumber	rland, MD 21	502
0.00	Physician /Medical	e 0	23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on each lin	a consequence of):	Tafare		y arrest,	Approximate Interval Between Onset and Death
	Examiner page 155	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Coro	1	rtery D	isease		Years
8760, <	cate be executed physician and the burial-transit	dical Exar	that initiated events ' resulting in death) Last	CDue to (or as a	a consequence of):				
P.O. Box 6	the death certific by the attending pached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3[	□Ectopic pregnancy □ Other (specify)			ate of delivery onth Day Year
ecords, P	w requires that been signed to should be deta	pleted by Pl	Part II. Other significant condition Hypertensi	-				id tobacco use cor □ Yes 2 No	ntribute to the cause of death
၁၁	law re as bee 2 sho	plet	Hypertensi End-Stage	Renal 7	Disease	اح	24a. W	as an 24b.	Were autopsy findings availa

3 ☐ Probably 4 ☐ Unknown

autopsy performed? 1∐ Yes 2 ₩ No Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2√ No

39947 3. Time of Death

10:16 P M

9. Birthplace (State or Foreign Country)

MD

10d. Inside City Limits 1 Yes 2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D46346

29d. Date signed (Month, Day, Year) December 07, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lasci

28a. Date of Injury (Month, Day Year)

Hospital:

21502 Dr. H. Shakil, Johnson Heights Medical Bldg, Cumberland, MD

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

25. Was case referred to medical examiner?

27. Manner of Death

1 🙀 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

Be Com

Certification: To

Medical

State

DEC 1 4 2006

5 ☐ Pending investigation

6 ☐ Could not be

determined



Registrar DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director, After this certificate is completely filled in by the funeral director, page

Division or Vital Re

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

•		For State	iato of Marylana	Certif	icate of	Death	R	teg. No. 200	c 2001.0
Physician/	1	. Decedent's Name (First, Midd					2. Date of Dea Month Decembe		-8. Time of Death
Medical Examine		Thurman Benne  Ia. Facility Name (if not institute)	ett Waugh_		14	o. City, Town, or Location		r 3, 2006 4c. County of Deat	
3		119 W. Main Street	on, give street and number)		"	Hancock	TOT DOGITH	Washington	
Funeral	Ę	Social Security Number	6. Sex 7. Ag	e (In yrs. last	birthday)			rth(MM/DD/YYYY) 9. Bi	
Director	1	235-68-8800	1X M 2 F		60 Yrs.	Months Days Hou	rs Min. Decembe	r 01,1946 Forei	ountry) MD
8	_	Jsual Residence of Decedent		40a City To	wn or Locatio				10d. Inside City Limits
ow an		0a. State 10b. County				11			1 X Yes 2 No
te Maryland or 28a-f show any fred at once.	<u> </u>	MD Washi	ington	наг	ncock	10f. Zip Code		10g. Citizen of What Cou	21
the Maryland a or 28a-f sh tifted at one Director	3	119 West Main	Street			21750		USA	
leath with tritems 23a		1. Marital Status	12. Was Decedent			Decedent of Hispanic Or		o- 14. Race - Amer	rican Indian, Black,
215-0036 be filed within 72 hours after death with the Maryland natal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once Be Completed by Funeral Director		1 Never Married 2 N	1 X Yes 2	No		s, specify Cuban, Mexica		White, etc.	
raffer niner	şĻ	3 Widowed 4 X Di  15. Decedent's Education (Spe	vorced If Yes, Give Year 196	5-1968		Yes 2 X No specify s Usual Occupation (Give		Specify: 16b. Kind of Business	White
21215-0036 uld be filed within 72 hours at Mental Hygiene. marked other than "natural revent, the Medical Examin	3 -	Elementary/Secondary (0-12)				st of working life. DO NO		Too. Kind of Edulitose	madetry
036 thin 7 ne. r than ledica		12			Lal	orer		Road Const	truction
5-0 lled will Hygie I other I the M		17 Father's Name (First, Middle	*	•		18.Mothe	er's Name (First, Middle,		
2121 Ild be fi Mental I narked event.	\$	Sylvester Wat 19a. Informant's Name/Relation	ship (Type Print )		19h Mailing	Address (Street and No	oel Flowers	mber, City or Town, State	7 7 Code
AD 21 2 should h and Me 27 is ma imatic ev	- 1	Alona Mills/Dau						Fordsburg, PA	
e, N I and S Health item		20a. Method of Disposition				ion (Name of cemetery,	Date	20c. Location - City of	
imore, MD 21215-0036  Perges I and 2 should be filed within 72 hours after death with the Maryland Pert of Health and Mental Hygiene.  This is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		1 Burial 2 X Crematio 4 Donation 5 Other S		ate		g Crematory	12/05/06	Smithsburg	∍. MD
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Comple		1. Signature of Funeral Service	e Licensee		22. No	ame and Address of Facil		41 West Main	
	1	23a Part I. Enter the disease, o		the death De	Gro	ove Funeral	Home, P.A. I	Hancock, MD 2	21750-0368 Approximate Interval
Physician /Medical		failure. List only one cause	e on each line.	101	o not enter ur	s mode of dying, sacri as	cardiac of respiratory ar	rest, shoot, or heart	Between Onset and Death
Examiner		Immediate Cause (Final diseas or condition resulting in death)	e a. <u>Seizure di</u> Due to (or as a cons						<del>                                     </del>
and the second		Sequentially list conditions,	b						
ted I Insit Examiner		if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of):					
sit sit	Ya	(Disease or injury that imitlated events resulting in death) Last	Due to (or as a conse	equence of):					
		X UNPENDED	d						†
760, iteate be executed by spiking and the burial - training the burial - training Medical	2	F FEMALE:	#23 23c. If yes, outcor	a.27.28a	a-f. per	ME. g863, 1/8/	07 TT	23d. Date of deliver	y
687(certifical certifical	3b. Was decedent pregnant in past 12 months?	the 1 Live birth		2 Feta	at death 3 Ector	pic pregnancy	Month	Day Year	
b. Box 68 the death certif oy the attending ched for use as Physician	2	1 Yes 2 No 9 Ur	nknown 9 Unknown	time of death	5 Oth	er (Specify)		440	
ing Physician: The law requires that the death certificate has been signed by the attending uneral director, page 2 should be detached for use as in To Be Completed by Physician		Part II. Other significant cond	itions contributing to deat	h but not resu	ulting in the ur	nderlying cause given in I	Part I. 23e Did t	obacco use contribute to	the cause of death?
P. C. Ires that signed is be det							1Ye	es 2 No 3 Pro	bably 4 🗸 Unknown
ords  * requ s been should	212						24a Was auto	psy prior to	utopsy findings available completion of cause of
Records, The law require, ficate has been sig., page 2 should b.	5						,1 <b>✓</b> Yes	ormed? death? 2 No 1 ✓ Y	es 2 No
Division of Vital Records, P.O. tale or Attending Physician: The law requires that it as after death.  Fin Directors. After this certificate has been signed by led in by the funeral director, page 2 should be detacentification: To Re Completed by B.	וע	25. Was case referred to medic examiner?	Henritel:			Other	h (Check only one)		_
n of Vital I Jing Physician: After this certifi funeral director,	2	1 ✓ Yes 2 No 27. Manner of Death	I Inpatie		R/Outpatient 8b. Time of In		Nursing Home 5 rk? 28d. Describe	Residence 6  Othe	er: Scene
	5	1 Natural 5 Per	28a. Date of Inju (Month, Day, Y			1 Yes 2 5	7 No		
ivisic 1 or Atte after dea Directo d in by th	2		estigation UNKNOWN 28e. Place of Ir		<b>nknown</b> e, farm, stree	, factory, office building,		Street and Number or R	ural Route Number, City
Division o ospital or Attending hours after death meral Director: After y filled in by the fune Centification:	200		arminad (a ir )	known_			or Town, unknown	State)	
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. After this certif completely filled in by the funeral director, completely filled in by the funeral director.	2 2	Check only	Physician: To the best of maniner:On the basis of exa						
To the Ho within 24 To the Fu completely	jed -	one) 2 Medical Ex  29b. Signature and title of certif	and manner stated	Third and	- Invoorigan	29c. License numbe		29d. Date signed (Mo	
	1	AAI h	1 ( / 1)	1		O.C.M.E.		December 4, 20	
		30. Name and address of person		leath (Item 23	Ba)				
		Melissa Brassell, MD			r 111 P	enn Street, Baltimo	ore, MD 21201		
Stat Registra	-	31. Date filed (Month, Day, Year DEC 1 4	2006 32 Registra	r's Signature	Sheer	es.			_
DHMH 17 Rev 1/200			. 2000 garage		ORIGINAL				

			1 - For State Registrar	State of Mary	/land / Dep		of Hea	Ith and N	R	jiene <sub>eg. No.</sub> 2		3994
	Physici		Decedent's Name (First, Middle, Las CHARLES HERB		HT, JR	•			2. Date of Dea DECEMB		2ď86	3. Time of Death
,	/Medi Examir		4a. Facility Name (If not institution, give	St.		Ceci	lton	ation of Death		Cec		
	Funeral Director		5. Social Security Number 6. Sr 215-68-4216 1  Usual Residence of Decedent		n yrs. last birthday) 52 Yrs.			Under 24 Hrs. ours Min.	8. Date of Birth (Month Day Apr 1	<sup>Y</sup> 1 <sup>3</sup> 954	9. Birthpl F101	lace (State or Foreign 10 10 10 10
	the Maryland 28a-f ehow	rector	10a. State 10b. County MD Cecil 10e. Street and Number		oc. City, Town or Lo Ceciltor		Code		1	Oa. Citizen o	of What Coun	od. Inside City Limits  1    Yes 2   No  try?
980	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Menial Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show sny Injury or other treumatic event, it a Mudical Exactions inval be notified at Once.	by Funeral Director	137 East Main  11. Marital Status  1 KN Never Married 2 Married 3 Widowed 4 Divorced	St.  12. Was Decedent Eve Armed Forces?  1 ঐYes 2 ☐ No If Yes, Give Year or Dates: — 1	1972	219 Was Decede If Yes, specifi	ent of Hispan fy Cuban, Me		pecify Yes or No- D Rican, etc.)	U.S.	A . ace - America lack, White, e	an Indian,
Maryland 21215-0036	filed within 72 ho Hygiene. Ither then "naturent, It e Medical	<b>Completed</b>	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12) 1 2	cation de completed) Collège (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use nting	done during retired) Cont	g most of work	r E	Resid		l Homes
Marylan	12 should be filed withir h and Mental Hygiene 7 le marked other then treumatic event, it e Mi	To Be	Charles Herbe:  19a. Informant's Name/Relationship (7 Patricia Taylo	ype, Print)		ng Address (	Street and N	Patric	ia Stip	oa , City or Tow	n, State, Zip	Code)
Baltimore,	nit. Pages 1 and artment of Heelth ortant: If Item 27 Injury or other tr		20a. Method of Disposition  1 2 Burial 2 Cremation 3 4 Donation 5 Other (Specify  21. Signature Fun of Service Licenses	Removal from State	20b. Place of Dispo cemetery, cres Galena	osition (Name matory or oth Ceme	e of ner place) tery	12/9	Date / 06 (	<sup>20c.</sup> Location Galena	a , MD	
Ba	permit. I Departm Importar eny Injur		100	МОС							MB. I	1635
68760, 🗸	death certificate be executed  Be attending physicien and strensis as the burial-transit	Ilcal Examiner	23a. Part1 Ente/ the disease, or come shock, or locart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Wy Ca  Due to (or as a co  Due to (or as a co  d	rated of:		arct		or respiratory arm	est,		Approximate Interval Between Onset and Death
P.O. Box 6	at the death certifical by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 ☐	Ectopic pred					ate of deliver	y Day Year
	The law requires that the ste has been signed by the page 2 should be detache	Ď	Part II. Other significant conditions co	ntnbuting to death but no	ot resulting in the u	nderlying cau	use given in i	Part I.		oacco use col	ntribute to the	cause of death?
Vital Records,		e Completed	25. Was case referred to medical							ned?	Were autop prior to com death? 1 \( \subseteq \text{Yes} \) 2	sy findings available pletion of cause of
of Vi	Physician: r this certific ral director,	ToB	examiner? 1≝Yes 2□ No		2 ER/Outpatien		O+		me 5 Reside		ther (Specify)	
Division of	anding sath. or: After he fune	Certification:	27. Manner of Death  1 Vatural 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Ye.		М	c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe ho			
DİVİ	= B = C	Certif	4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	pecify)				28f. Location (St. City or Town	, State)		
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier 1 Certifying Phyone) Constant only 2 Medical Exam	sician: To the best of my ner. On the basis of exa and manner stated.	y knowledge, death imination and/or inv	occurred at restigation, if	the time, da n my opinion	ite and place, i, death occurr	and due to the ca ed at the time, da	use(s) and nate and place	nanner as sta , and due to t	ted. the cause(s)
)	To the within 2 To the complet	Ž	29b. Signature and title of certifier				License num	_		-	ed (Month, D	ay, Year)
	Ku		30. Name and ad has of person who are the trey of the	my Hed cause of death	(Item 23a) (Type,	Print)	. 1	· · · · · · · · · · · · · · · · · · ·	ten, u		2192	
	Sta Registr		31. Date filed (Month, Day, Year) BEC 1 3 200	329 Registrar's	Signature State	مناه						•

				1 - For Amend	State of A	darylar Per	nd / Depa <b>verb</b> <i>Cei</i>	G862	t 95.H e of C	15/06	nd Men	tal Hygi	ene	06	39950
		Dhyois	ion	1. Decedent's Name (First, Middle, Last							2. [	Date of Death		Year	3. Time of Death
		Physic /Medi	cal	Robert H. Ayers							De	cerebro	× 10	2006	
		Exami	ner	4a. Facility Name (If not institution, give						Location of	Death		4c. Co	unty of Death	•
		Funeral		Upper Chesapeake  5. Social Security Number 6. Se	x 7.7		er . last birthday)	If Under	el Ai	If Under 24		ate of Birth		Harfo 9. Birth	rd  pplace (State or Foreign  untry)
		Director		218-20-3838	M 2□F	75	Yrs.	Months	Days	Hours		b 28m			untry) th Carolina
		and w		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
		Many of sho	ţō	MD Harford			Jopp	а							1 ☐ Yes 2√∑ No
		ih the	Director	10e. Street and Number			1, 1,	10f. Zip	Code			10	g. Citizen	of What Co	untry?
		ath wil	raiD	725 Joppa Farm	Road				2	1085				USA	
		or freme	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Forces	s?	J.S. 13. \	Was Deced f Yes, spec	ent of His	spanic Origin , Mexican, I	in? (Specify Puerto Ricar	Yes or No- n, etc.)		Race - Amer Black, White	
4	5-0036	of, or	<u>م</u>	3 Widowed 4 Divorced	1 ∑Yes 2 ☐ If Yes, Give Year or Dates		5/4	∏ Yes 2	No IX	Specify:			Spe	ecify: w	hite
0	2-0	within 72 hours after death with the Maryland ene. than "naturel", or fleme 23s or 28s-f show ha Madical Examiner must be motified at	Completed	15. Decedent's Edu (Specify only highest grad	cation	40-	16a. Deced	lent's Usua	I Occupa	tion	of working	1	6b. Kind o	of Business/I	ndustry
9	121	within ane. then	mpi	Elementary/Secondary (0-12)	College (1-4o	r 5+)				uring most o	a worming				
	<b>d</b> 2			12 17. Father's Name (First, Middle, Last)	0		p	rinte		18. Mother's	s Name (Firs	st, Middle, M		rintir	ng
	ılan	0 0 0	To Be	Robert Howard Ba	iley Aye	rs				Irer	ne Kat	herine	Pet	erson	
2/10/00	Maryland	2 sh and and is m		19a. Informant's Name/Relationship (T)						nd Number	or Rural Rou	ite Number,	City or To	wn, State, Z	ip Code)
0		f Health item 27 other tr		Lois Hiller/daug	hter	20h I	The second secon		-	r Cour	ct Woo				
0	Jor	of of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from Stat		Place of Dispo- cemetery, cren			)	Date	2	Oc. Location	on - City or T	Town, State
0	altimore,	교육분급 .		4 ☑ Donation 5 ☐ Other (Specify)  21. Si nature Luneral Service icens	ee //		22	. Name and	d Address	of Facility		-			
_	B	Depa impo eny i		Ronald S.	19/1	ecto	rSt	ate A	Anato	my Bo MD 2	ard 65	55 W.	Balti	more	Street
6	8760,	that the death certificate be executed with the attending physicien and by the attending physicien and color of the attended for use as the burial-transit color of the attended for use as the burial-transit color of the attended for use as the burial-transit color of the attended for use as the burial-transit color of the attended for use as the burial-transit color of the attended for use as the property of the attended for use as the property of the attended for use at the attend	dical Examiner	23a. Part   Enter the disease, or complete shock or heart failure. List only or limited and complete shock or heart failure. List only or limited and complete shock or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	a consecutive a	quence of):				ardiac or resp		st,		Approximate Interval Between Onset and Death
18100	.O. Box 6	it the death certific by the attending pl tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta at time of d	al death 3 🗌	Ectopic pre Other (spe					1	Date of deliv Month	very Day Year
0 #	rds, P	8 ig 8	ρ	Part II. Other significant conditions con	ntributing to death	but not res	sulting in the un	derlying ca	iuse giver	n in Part I.	2		_		the cause of death?
7	000	law requi	Completed	Soptie	Shoc	L					2	4a. Was an	24	b. Were aut	opsy findings available
4	Vital Rec	The Tate has page	Com									autopsy performe ☐ Yes 2	ed?	prior to co death? 1 \( \sum \text{Yes}	ompletion of cause of 2□ No
8	Vita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	1						f Death   Che				
6	of		2	1 Yes 2 No			ER/Outpatient 28b. Time of		Other Bc. Injury a	4 LI NUISI	ing Home				fy)
5	lo	Attending Physicien: r death. ector: After this certific y the funeral director,	ition	1 Ø Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D	ay Year)	Injury	M	Work?	a. es 2 ⊡No	i	escribe how	injury occ	curred	
yre	Divisi	or At fter c pirec in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	njury - At h etc. <i>(Specit</i>	ome, farm, stre fy)	et, factory,	office		28f. Le	ocation (Stre ity or Town,	et and Nu State)	mber or Run	al Route Number,
£		To the Hospitel or At within 24 hours after or To the Funeral Direction place of the funeral bit of the funeral by the funeral filled in by	Medical C	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the bes ner: On the basis and manners	of examina	owledge, death ation and/or inv	occurred a estigation,	it the time in my opir	, date and p nion, death	place, and do	ue to the cau the time, dat	ise(s) and e and plac	manner as se, and due t	stated. to the cause(s)
		With To t	Σ	29b. Signature and title of certifier		Kr	_	29c.	License	number		290	d. Date sig	ned (Month,	Day, Year)
	<b>,</b>			Long	100-	10	<i></i>	D	ØØ 9	535	68		_		2006
				30. Name and address of person who co	propleted cause of	death (Item	n 23a) (Type, F >	Print) 50			Chara				/
		Sta	te	31. Date filed (Month, Day, Year)		trar's Signa	ature	150	1/6	IR I	Tasy	land		1014	<i>I</i>
		Registr	ar	DEC 1 5 2008	The wa	15	SOBA	( )							

State of Maryland / Department of Health and Mental Hygiene Beverly Alexander-Bey 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day December 11, 2006 1920 hrs Medical Examiner Bever1v Alexander-Bey 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Saint Agnes Hospital Baltimore N/A 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director Country) MD 216-50-0080 1 M 2 X F 58 JAN 9 1948 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Yes 2 No 28a-f show N/A Baltimore death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country items 23a or 28a-ust be notified at 3415 East Elmley Ave 21213 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 14 Race - American Indian, 8lack 11 Marital Status must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces's 1 Never Married 2 Married 2 X No Yes Specify: Black hours after f Yes, Give Year Widowed Yes 2 X No specify: permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygen and Inforcant: If item 27 is marked other than "natural", Injury or other traumatic event, the Medical Examiner. ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Sales 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvin Smith Bertha Willis 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tanya Alexander/Daughter 5112 Groton Rd Baltimore, Maryland, 21206 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 12/14/06 Baltimore, MD Donation 5 Other Specify 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee C. Todd Dring implications that caused the death. Do not enter be each line Approximate Interval 23a Part I. Enter the disease Physician Between Onset and failure. List only one cause /Medical Death a right hemothorax with complications Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. vascular injury Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause Enter Underlying Cause Dialysis catheter placement (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last d. endstage renal disease and Physician/Medical UNPENDED AMENDED requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d Date of delivery phy the l Live birth 3 Ectopic pregnancy Month Dav Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✓ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has 1 performed? death? certificate Yes 2 ✓ Yes No 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25 Was case referred to medical Be examiner? Other<sub>4</sub> Hospital: 1 🗸 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ۵ 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) Dec 11, 2006 28b Time of Injury 28d Describe how injury occurred 28c. Injury at Work? After 27. Manner of Death Certification: Subject had dialysis catheter replacement 1000 hrs Natural Yes 2 🗸 No e Funeral Director: A 5 Pending death 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 1666 Sulphur Spring Road , Arbutus , MD determined (Specify) Other (Dialysis Center) Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day Year) O.C.M.E December 12, 2006 address of person who completed Theodore M. King, Jr., MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHIVIH 17 KeV 172001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Month Alan Haymaker Anthony 2006 December 10:55p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Fairhaven Health Center Sykesville Carrol1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, May 23 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral X**□M 2□F 218-16-7258 81 Yrs MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r then "naturel", or Items 23s or 28s-f ehow the Medical Exeminar must be notified at MD Carroll Sykesville 1X Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1943 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white þ 1946 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) insurance agent agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any lighty or other traumatic event 2008: James Elmer Anthony Sr. Dorothy Anna Haymaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Anthony Jr. (son) 3435 Jennings Chapel Rd., Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jennings Chapel Cem. 12-20-06 Woodbine, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Magazalaught Sterbert P.O. Box 195 Sykesville, ND 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hemorrhage Jubarachnoid days Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) attending physicien a for use as the burial-Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 110 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ဥ this 27. Manner of Death 1 PNatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) December 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Eldersburg MD 21784 MD William lan 1645 L Road -ibert 31. Date filed (Month, Day, Year) 32/Registrar's Signature State 2006 Registrar 15

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Physicia /Medica	ai .	1. Decedent's Name (First, Middle, Last)  MDH am mad  4a. Facility Name (If not institution, give s	AKram	)	4b City	Town or	Location of		Date of Dea	Day	20°C	5611:20#M
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Funeral Director	- 1	5. Social Security Number 6. Sex	7. Age (In yrs. 76		If Under Months	1 Year Days	If Under 2 Hours	Min.	Date of Birt (Month, Da O	h y, Year) 3 3(	9. 8 D F	Birthplace (State or Foreign Country) Pakistan
ehow	ō	10a. State 10b. County		ity, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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21215-0036 ad within 72 hours af giene. er than "natural", or i, the Madical Exam	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+) na				fice			Sove	cnmen	nt Worker
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Baltimore, permit. Pages 1 ar Department of Heel mportant: If Item 2 any Injury or other	- 1	20a. Method of Disposition  1 Durial 2 Cremation 3 R  4 Donation 5 Other (Specify)	emoval from State	Place of Dispo cemetery, cren haria	sition (Nam natory or ot	ne of ther place	)	Dat . 2/19	е	20c. Loca Khai	ation - City o	or Town, State City
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Vision of Vita Attending Physician: ar death. • ector: Atter this certific by the funeral director.		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Bc. Injury Work		286	d. Describe h			өспу)
Division  tel or Attendi s after death el Director: A ed in by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre	et, factory,	, office		28	Location (S City or Tow	treet and I n, State)	Vumber or I	Rural Route Number,
	edical	29a Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	icien: To the best of my known and manner stated.	wledge dutth ation and/or inv	estigation,	it the time in my opi	o date and nion, death	Jane a no occurred	dua to the c at the time, o	ause(s) ar late and pi	ace, and du	ue stated. ue to the cause(s)
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920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23e or 28e-f ehow may injury or other treumatic event, ir a Medical Expira art must be redilled at once.	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces?  1 ∑Yes 2 □ No WW] If Yes, Give Year or Dates:	T	Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Specify:	White, etc. White
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	For State of Maryland  1 - Registrar	/ Department of Health and Certificate of Death	Mental Hygiene	
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Funeral Director	5. Social Security Number  167-32-4951    1	Vre Months Days Hours Mir		9. Birthplace (State or Foreign Country)  SC
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and and sand	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or F	Rural Route Number, City or T	own, State, Zip Code)
ore, IV	Kevin Carter / Grandson  20a. Method of Disposition 20b. Place	1505 Poplar Grove Aven		aryland 21216 tion - City or Town, State
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Baltimo permit. Pag Department Important: In any injury o once.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility 638 N. Gilmor Stree	Wylie Funeral H	Home, P.A.
	25a. Part1. Enter the disease of complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between
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To the within To the Comp	29b. Signature and title of certifier m	D 29c. License number D 3 ( Y 6 )		signed (Month, Day, Year)
3	30. Name and address of person who completed cause of death (Item 2	(13a) (Type, Print) N. Entaw St Sni	to 300 BAL	7/10/08F MN 2/20
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State of Maryland / Department of Health and Mental Hygiene 39956 Amend #16b perFH, G863, 1/2/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Day Month Year **Physician** 1:00 P.m RONALD BANNERMAN, SR. N. 3 2006 12 /Medical 4c. County of Deeth 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) Examiner - Roland Park Baltimore Manor Care If Under 24 Hrs. 8. Date of Birth (Month, Day) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 MM 2□ F 59 Yrs. 216.48.1196 MD Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f show the Modical Examiner must be notified at NIA MD Baltimore 1 XYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 29th Street 21218 West USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or that any injury or other traumatic event, the M-sitcal Exercition page. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑No Specify: Specify: Black Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Bethlehem Steel 15. Decedent's Education (Specify only highest grade completed) Poultry Elementary/Secondary (0-12) College (1-4or 5+) aborer unk unk 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Bannerman Ann Lee Frederick Arthur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 123 West 29th Street Baltimore MD 21218 Joyce Bannerman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/20/06 Baltimore, MD Cemetery Innitu 21. Signature of Funeral Service Licensee 22. Namp and Add of Facility Vaughn C. Greene Funeral Services York Road Baltimore MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ACQUIRED IMMUNUDEFICIENCY SYNDROME Examiner Due to (or as a consequence of): Physiclan/Medical Examiner ettending physician and for use as the buriel-transit The law requires that the death certificate be executed sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of). 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown MYPERTENMIVE CARDINASCULAR DISEASS þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? DIABETES MELLITUS has 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending efter death.

Director: Aft in by the fur 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours e To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059107 M.D 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) CENTER DRIVE, REISTERSTOWN BUSINESS MD 21136 UMA 210 31. Date filed (Mo Year) 32. Registrer's Signature State 2006 Registrar

06-09173 Steven Blue

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certi	ficate of Death		g No. 2006 3995
Physician/ Medical Examiner	Decedent's Name (First, Middle,L			2. Date of Deat Month December	
et en	4a Facility Name (if not institution, g Johns Hopkins Bayview		4b. City, Town, or Location (	of Death	4c. County of Death
Funeral Director	220.94.5220	Sex 7. Age (In yrs. last 29	birthday) If Under 1 Year If Under 1 Year Months Days Hours	Min.	th(MM/DD/YYYYY) 9. Birthplace (State or Foreign Country) MD
vlaryland 28a-f show any d at once. ector	Usual Residence of Decedent  10a. State  10b. County  N		own or Location  MORE  10f. Zip Code	130	10d. Inside City Limits 1
ath with the Maryland items 23a or 28a-f sho ast be notified at once. ineral Director	10e. Street and Number 6126 FORTVIEW	WAY	21224		USA
· · · · · · · · · · · · · · · · · · ·	11. Marital Status 1	12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No ed If Yes, Give Year	13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican  1 Yes 2 L. No specify		14. Race - American Indian, Black, White, etc.  Specify: BLACK
21215-0036 uid be filed within 72 hours after Mental Hygiene marked other than "natural", everut, the Medical Examiner To Be Completed by I	15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade completed) 1  College (1-4 or 5+)	6a. Decedent's Usual Occupation (Give during most of working life. DO NOT		16b. Kind of Business/Industry
8 5 5 6	17. Father's Name (First, Middle, La	N A	CARPENTER 18.Mother	's Name (First, Middle, N	HOME IMPROVEMENT Maiden Surname)
	JOHNNY B. BU		19b. Mailing Address (Street and Nur		
MD and 2 sho alth and 2 is ra 27 is raumati		IMELL (COUSIN)	902 BUNCHE RD.		
Baltimore, MD 2 permit Pages I and 2 shou Department of Health and M Important: If item 27 is n injury or other traumaric	1	Removal from State ore fy:	matory or other place)	12.14.06	BALTO. MD
	Vanonn CL		22 Name and Address of Facility VAUGHN C- GREE 5151 BAUD. NATO to not enter the mode of dying, such as a	PIKE, BHUC	). NIO 21229
Physician /Medical Examiner	failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)			ardiac of respiratory and	Between Onset and Death
red SC Insir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death). Last	b.  Due to (or as a consequence of):  Due to (or as a consequence of):			
c execution and challents and and and and and and and and and and	UNPENDED	dAMENDED			
Ox 68 ath certificant earling or use as a sician		23c. If yes, outcome of pregna 1 Live birth 4 Pregnant at time of deat	2 Fetal death 3 Ectopi	c pregnancy	23d Date of delivery  Month Day Year
6)	obesity	s contributing to death but not res	ulting in the underlying cause given in P		bbacco use contribute to the cause of death?  2 No 3 Probably 4 Unknown  1 24b. Were autopsy findings available
2 a a 2 E				autop	prior to completion of cause of death?
	examiner?	Hospital: 1 Inpatient 2 ✔ E	26 Place of Death  R/Outpatient 3 DOA Other		Residence 6 Other:
n of Vinding Phys h : After this e funeral di		(Month, Day, Year)	28b. Time of Injury 28c. Injury at World 1 Yes 2		now injury occurred
	2         Accident         Investig           3         Suicide         6         Could redeterm           4         Homicide	ation 28e. Place of Injury - At hon	ne, farm, street, factory, office building, e	tc. 28f. Location (\$ or Town, \$	Street and Number or Rural Route Number, City tate)
To the Hospi within 24 hos To the Finne completely fi			e, death occurred at the time, date and pl d/or investigation, in my opinion, death o		
T % F %   W	Margainte of	e Yhile	29c License number O.C.M.E.		29d Date signed (Month, Day, Year)  December 3, 2006
		Assistant Medical Examine	r 111 Penn Street, Baltimore	e, MD 21201	
State Registra		2006 32 Registrar's Signature	1 Sparle		

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

			1- State of M Registrar	aryland / Depa	artment of H <i>rtificate of L</i>			ene 1. No. O O O	
	Physici		1. Decedent's Name (First, Middle, Last)	<u>'</u>			2. Date of Death Month	Day Ye	3. Time of Death
-	/Medic		Kevin Leigh Brophy  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	December	4c. County of E	
<i>)</i> :			Union Memorial Hospital			timore		,	N/A
	Funeral Director		217-60-0017 1 <sup>™</sup> 2□ F	ge (In yrs. last birthday) 53. Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	'ear) 9.	Birthplace (State or Foreign Country)  Maryland
	land w t		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl a-f sho fled a	tor	Maryland N/A		Baltimor	**			1 X Yes 2 No
	or 282	Director	10e. Street and Number		10f. Zip Code	e	10g	j. Citizen of Wha	t Country?
	s 23a nust b		3427 Woodstock Avenue			21213		U.S.	
36	be fled within 72 hours after death with the Maryland Hygiene. Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 Married  1 □ Never Married 2 Married  1 □ Yes 2 Married  1 □ Yes 2 Married  1 □ Yes 2 Married  1 □ Yes 2 Married  1 □ Yes 2 Married	No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		American Indian, White, etc.
5-0036	2 hour aturali cal Ex		15. Decedent's Education	16a. Dece	dent's Usual Occupa	ation	16	b. Kind of Busine	White ess/Industry
215	thin 72 ie. an "na Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or \$\frac{1}{2}\$)	(Give	kind of work done d DO NOT use retired)	lurina most of work	ing	io. Ring of Busine	ess/moustry
12121	filed wi Hygien ther th		12th Grade		Shipping A				Baltimore
⊆	be d c	o Be	17. Father's Name (First, Middle, Last)  Maurice Brophy				e (First, Middle, Ma		
ary	s 1 and 2 should f Health and Men ftem 27 is marke other traumatic	ဥ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a		ste Adria:		te. Zip Code)
	1 and 2 Health a tem 27 is		Deborah Brophy (Wife)						yland 21213
Baltimore,	iges 1 ai nt of Hea if item or othe		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State	cemetery, cren	osition (Name of matory or other place	1	Date 20	c. Location - City	or Town, State
<u>=</u>	permit. Pages 1 Department of H Important: If ite any injury or ot once,		4 □ Donation 5 □ Other (Specify)  21. Sign ture of Funeral Service Licensee		Crematory		3/2006 Ba	altimore	, Maryland
g	Depa Impo any	d d	Itefamio Kin	eke 3.	2. Name and Address 331 Brehms	s Lane, I	Baltimore,	, Maryla	ome Inc. and 21213
F	Physician		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition	Lana III	er the mode of dying	g, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
	/Medical		resulting in death)	a consequence of):	TION	1 anor			30 minutes
N	Examiner	_	Sequentially list conditions, b. Due to (9)	icardial	Intar	ction			I week
>.	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	a consequence of):					unknown
o,	an and rial-tra	Exa	regulting in death) least	a consequence of):	OPI				UNKNOWN
68/60,	tificate be executed g physician and as the burial-transit	edical							
	certific iding p		IF FEMALE: 23c. If yes, outcome	nf pregnancy			· · · · · · · · · · · · · · · · · · ·		
ž Po Po	the death cert y the attending iched for use a	Physician/M	in the past 12 months?  1 Ves 2 No 4 Pregnant at	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
5	at the by the stacher	hys	9 ☐ Unknown						
S,	res t igne be c	þ	Part II. Other significant conditions contributing to death but	ut not resulting in the un	nderlying cause giver	n în Part I.			e to the cause of death?
cords,	v requi	eted					1 Yes	2 No 3	Probably 4 Unknown
Ě	the faw i ate has be page 2 sh	Completed					24a. Was an autopsy performed	prior	autopsy findings available to completion of cause of n?
	rtificat	മ	25. Was case referred to medical			26 Place of Death	1 Yes 2 V	No 1□Y	
> 0	Pnysician: r this certific ral director,	ToB	examiner? 1 Yes 21 No Hospital: 1 Inpatie	nt 2 ☐ ER/Outpatient	Othor		me 5 Residence	e 6 □Other <i>(S</i>	Specify)
	After th		27. Manuer of Death 1 ☑ Natural 5 ☐ Pending (Month, Day		28c. Injury Work?	at ?	28d. Describe how i		
2	death.	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be   380 Place of initial	ıry - At home, farm, stre		es 2 No	006 1 1' (0)		
2	To the nospira or trateding Prysician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	4 Homicide determined building, etc	:. (Specify)	set, factory, office		City or Town, S	t and Number or tate)	Rural Route Number,
	Hosp 24 hou Funer etely fill	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of Medical Examiner: On the basis of And manner sta	examination and/or inv	occurred at the time estigation, in my opi	e, date and place, inion, death occur	and due to the caus red at the time, date	e(s) and manner and place, and o	as stated. due to the cause(s)
3	within Fo the	ĕ Me	29b. Signature and title of certifier	ied.	29c. License	number	29d.	Date signed (Mo	onth. Day, Year)
<u> </u>	71-0		Duant thoto Mi	D.	ATO	4389	46 Do	C+mha	11 7006
	10		30. Name and address of person who completed cause of de			. 001	/ //	1	1,200
2.34	,		1. Date filed (Month, Day, Year) 32 Registra	M.D. U.	nion Me	morial	Hospit	al, MI	)
	Stat Registra	~ /	ST. Date filed (Month, Day, real)	A Songriature	all &				

			1 - For State Registrar	State of Marylar		artment of H			iene •g. No.200	6 39959
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea		3. Time of Death
2.0%	Physici /Medio		Donal Levi	Brison				Dec.	11, 200	L.A
7	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of De	ath	4c. County of	
			Franklin Square	e Hospital		Roseda	ale		Balt	imore
	Funeral		Social Security Number     6. Sex			If Under 1 Year Months Days	If Under 24 H Hours Mi	rs. 8. Date of Birth	Year)	). Birthplace (State or Foreign Country)
	Director		440-30-0004	M 2□F 7	4 Yrs.			Aug. 7	1932 C	)klahoma
	pur *		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits
	lary!	5	MD Baltin		-	le River	2			1 ☐ Yes 2X No
	28a-	Director	10e, Street and Number			10f. Zip Code		1	0g. Citizen of Wh	at Country?
	With Ba or		36 Right Wing	Drive		2122	20		USA	,
	ns 23	Funeral		2. Was Decedent Ever in U	J.S. 13. \	Was Decedent of Hi	ispanic Origin?	(Specify Yes or No-	14. Race -	American Indian,
<b>'</b> O	fer of the result of the resul	표	1 ☐ Never Married 2 ★ Married	Armed Forces? 1X7Yes 2 ☐ No	'	f Yes, specify Cuba	n, Mexican, Pu	erto Rican, etc.)	Black,	White, etc.
ဗ္ဗ	al', o	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
20	within 72 hours after deeth with the Maryland ene. Itan "natural", or Items 23e or 28e-f ehow Ita Madical Exp.:timer.cust be notified at	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	dent's Usual Occupa	ation during most of w	rorkina	16b. Kind of Busin	ness/Industry
2	ithin	agu	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	oo NOT use retired eral For	)		Volcar	Hart Co.
2	filed w Hygier other th	S	9th		Gen	erar roi		(=:		
밀	m = V S	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle, i	Maiden Sumame)	
3	should be ad Mental marked c matic eve	ဥ	Floyd Brison	- <b>G</b> ∹-N	405 14-75			L Huff	. C' T	- T- O- d-1
Maryland 21215-0036	12 st hand 7 le n traun		19a. Informant's Name/Relationship (Type			100.0		Rural Route Number		
e,	1 and Healt em 2 ther		Nancy Lee Bris		the state of the s	sition (Name of	wing i	Orive Ba	20c. Location - Ci	
Baltimore,	ages nt of t: If it		1 Burial 2 ☐ Cremation 3 ☐ Re			natory or other plac Memoria		115/00	Cumberl	
ᄩ	it. Partme		4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service License			. Name and Addres	15.00	<u> </u>		
Ba	permit. Pages 1 and 2 should by Deperment of Heath and Menta Important: If Item 27 is marked eny Injury or other traumatic evonce.		Patrick O	Perns						Balto. MD
	_		23a. Part 1. Enter the disease, or complic	cations that caused the dea				cal Home		Approximate
all/			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	_	,				Interval Between Onset and Death
ADDRAG.	Physician /Medical		disease or condition resulting in death)	Due to (or as a consec	quence of):	220				
	Examiner			Reman	4	Faila	0			
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence	-				
	and and I-transit	Examiner	Cause (Disease or injury that initiated events	Paris	on	Dee	line			
oʻ	en ar en ar rial-ti	EX	resulting in death) Last	Due to (or as a nsec	quence of):	Λ 1-	ine Dr	-		
8760,	Atending Physician: The law requires that the death certificate be executed to death. The third that the triangle of the certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	dlcal	L d		m	128/200	Dr	slave.		
39	ing pl	Med	IF FEMALE:			•				
Вох	eath certific ettending p for use as	lan/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1☐Live birth 2☐Feta	al death 3	Ectopic pregnancy			23d. Date of Month	
<u>.</u>	e de: the e	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of a 9☐Unknown	death 5□	Other (specify)				
<u>~</u>	that the di ed by the detached	P.	Part II. Other significant conditions con	tributing to death but not re-	eution in the w	nderlying cause give	en in Part I	23e. Did tol	pacco use contribi	ute to the cause of death?
Division of Vital Records, P.O.	w requires that s been signed t should be det	d by	Hunster Co.	induiting to dodin but not not	Jeg	out of the second secon				☐ Probably 4 ☐Unknown
Ö	r requ	etec	Coffee	1 1	P. 0		Den	24-14		
ခိုင	The law cate has l	Completed	Ummu C	bothictme	100	minay	Susen	24a. Was a autops perform	n 24b. we sy pric ned? dea	re autopsy findings available or to completion of cause of ath?
<u>a</u>	i <b>cian</b> : Th certificate rector, pag							1 ☐ Yes	2 □ 1 □	Yes 2□No
<b>\rightarrow</b>	sicial certii recto	Be	25. Was case referred to medical examiner?	ospital:	7.ED/O	Othe	ar	eath (Check only on	6	(0
ō	Phy:	5. To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of			Home 5 Reside	w injury occurred	(Зреспу)
on	th. Afte	를	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		(? Yes 2∐No			
<u> S</u>	Attend r death ector: / by the f	ffca	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h	ome, farm, str	eet, factory, office		28f. Location (St City or Town	reet and Number	or Rural Route Number,
Ö	s efter s efter it Direct	Certification:	4   Homicide	building, etc. (Speci	<i>1y)</i>			City bi Town	i, State)	
	To the Hospital or Attending Physician: within 24 hours efter death. To the Functal Director: After this certific completely filled in by the funeral director.			ician: To the best of my knier: On the basis of examina						
	in 24 in 24 in 6 in 6 in 19	Medical	one)	and manner stated.	ation and/or in					
	To T	Σ	29b. Signature and title of certifier		MO	29c. License	211 61		9d. Date signed (	
7	1		) / CVA	~	MD	1 / 3	1464	1	2/11/0	) (
	6		30. Name and address of person who con		m 23a) (Type,	Print)	Guto	300 PM	Aitlman	2E mn 21201
	\		SHOA(13 A. HAS	/ 1/4	V. CV	person 21	muc	707 0	, , , , , , , , , , , , , , , , , , , ,	
	Sta Registr		DEC 1 5 2	32. Registrar's Sign	J. F.					

		•	For State Registrar	Oldic O	i mai y ta		artment of F rtificate of		ia montani	Reg. No	71116	39960
			Decedent's Name (First, Middle, Landson L	ast)					2. Date of I	Death		3. Time of Death
	Physicia		Hertline				Banks		Month	Day	Year 3, 2006	2:48 A M
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and nur	nber)		4b. City, Town, o	r Location of I			County of Death	
	Laumi		6536 Princess Ga	rden Par	kwav		Lanham			F	rince G	eorge's
	Funeral		Social Security Number 6.	Sex		s. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of E		9. Birth	place (State or Foreign
	Director		421 <b>-</b> 30 <b>-</b> 05 <b>9</b> 0	1 ☐ M 2 🕅 F	91	Yrs.	Months Days	Hours	May 10	, 191		abama
	pu ,		Usual Residence of Decedent		100.0	City, Town or Lo						40d Incide City Limits
	shov	1	10a. State 10b. County			Jity, TOWN OF LC	cation					10d. Inside City Limits 1 1 Yes 2 □ No
	8a-f	Director		George'	S	Lanham						
	or 2		10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Cou	untry?
	eth v		6536 Princess Ga				20706				S.A.	
	er de	Funerai	11. Marital Status	12. Was Dece Armed Fo	rces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origir an, Mexican, F	n? (Specify Yes or I Puerto Rican, etc.)	No-	<ol> <li>Race - Amer Black, White</li> </ol>	
36	hours after deeth with the Maryland turel', or Iteme 23a or 28a-1 show at Examinational be multified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes If Yes, Giv Year or D	/8		1 ☐ Yes 211 No	Specify:			Specify: R1	ack
8	hour turel	be	15. Decedent's E		4105.	16a Dece	dent's Usual Occup	nation		16b K	ind of Business/li	
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State of Maryland / Department of Health and Mental Hygiene 3996 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 7:45  $A^{M}$ 9, 2006 Emma Mary Brown-Kreisberg December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Columbia Howard Sunrise Assisted Living If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🕅 F 95 RT 108-07-3567 Director Feb. 6, 1911 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 X No Director Maryland | Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 6500 Freetown Road U.S.A. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 💹 No Specify: Specify: White δ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Piano Teacher 12 Music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vincent Valente Anna Filosa 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Brown (Son) 14 Unity Dr., Centereach, NY 11720 20b. Place of Disposition (Name of Cometer), crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State National Cemetery 4 Donation 5 Dother (Specify) 12/15/2006 Pinelawn, NY 21. Sig sture of Juneral Service Linensee 22. Name and Address of Facility Commack Abbey ennis Mimeur 96 Commack Rd., Commack, NY 11725 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COMPLICATIONS FROM DEMENTIA **Physician** YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in reclict cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PRESBYESOAHAGUS HYPEXTENZION HIATAL HERNIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No J<sub>0</sub> this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Medical Certification: 1 Natural 2 Accident 5 Pending investigation within 24 hours after deam.

To the Funeral Director: AF 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifie 138296 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIPG LARK BROWN RD, SUITEZOI, ELKRIDGE, MD F.VGIBBONS, MJ 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

2006

06-09435 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Keith Barney, Jr. 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ Barney, Jr. 0320 hrs Keith **Medical Examiner** December 11, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death NA University Hospital Baltimore 9. Birthplace (State or 5. Social Security Number If Under If Under 24Hrs. Date of Birth (MM/DD/YYYY) 6. Sex 7. Age (In yrs. last birthday) Year **Funeral** Country) Md. Months Davs Hours Min. 9-3-1976 Director 212-90-5480 1 M 2 X F 30 Usual Residence of Deceden 10a. State 10c. City, Town or Location 10d Inside City Limits 1 X Yes 2 No 28a-f show once. Baltimore NA e, MD 21215-0036
I and 2 should be filed within 72 hours after death with the Maryland Health and Menial Hygiene. Director 10f. Zip Code 10g, Citizen of What Country 10e. Street and Number notified at USA 21223 2443 Edmondson Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, 12. Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) X Never Married 2 Armed Forces? Married Yes Widowed Divorced If Yes. Give Year 1 Yes 2 X No specify: Specify: Black marked other than "natural", c event, the Medical Examiner ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NA Unemployed 10th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shirley Fox Be Keith L Barney, Sr. 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is n 5610 Gwynndale Avenue, Baltimore, Md. Father Department of Health ar Important: If item 27 injury or other trauma Keith L. Barney, Sr. 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a, Method of Disposition Baltimore, X Burial 2 crematory or other place) Cremation 3 Removal from State 12-16-06 Randallstown, Md. Donation 5 Other Specify Kina Mem. Pk. 22 Name and Address of Facility 21. Signature of Funeral Service Licenses March F.H. E J 21202 1101 E. North Ave. Part I. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical physician a UNPENDED AMENDED death certificate be 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year 1 Live birth Month Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o signed by ş 1 Yes 2 V No 3 Probably 4 Unknown σ. Completed of Vital Records. peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? performed? this certificate Yes 2 ✓ Yes 26 Place of Death (Check only one) Physician: 25. Was case referred to medical Be examiner? Other<sub>4</sub> Hospital: 1 / Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 1 Yes No 28a. Date of Injury (Month, Day Year) Dec 9, 2006 28b. Time of Injury 28d. Describe how injury occurred Manner of Death 28c. Injury at Work? Attending Certification: Subject was shot 2320 hrs Division Natural 1 Yes 2 V No death Pending 24 hours after death Funeral Director: 2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 10 Could not be Suicide 4400 Block of Haddon Avenue, Baltimore, Md. (Specify) Parking Lot Hospital determined 4 V Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal within. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. December 13, 2006 mis 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 32 Registrar's Signature State 2006 Registrar

			For	State of M	aryland / Dep	artment of F	lealth and N			000	. 0000
			State Registrar		Ce	rtificate of	Death		Reg. No.	בוון.	3. Time of Death
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e is	Examin		4a. Facility Name (If not institution				r Location of Death			ty of Death	
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	Funeral Director		5. Social Security Number 083–58–6899	6. Sex 7. Ag 1  M 2	ge (In yrs. last birthday 76 Yrs.	Months Days	Hours Min.	June 2	y, Year)	Coun	lace (State or Foreign try) Germany
	yland sow at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location							1	0d. Inside City Limits 1 ☐ Yes 2K No
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	or 28%	ire	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Coun	itry?
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36	tter death the region of the r			If Yes, Give	Ever in U.S. 13 No	. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	Bi	ace Americ lack, White, cify: Whi	etc.
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, 10	Hygie Hygie ther int, th		17. Father's Name (First, Middle	 , Last)			18. Mother's Nan	ne (First, Middle	, Maiden Surn	ame)	
Maryland	d be ental ked o	To Be	August Friedri	ick			Augusta				e
ary.	shoul M mar	-	19a. Informant's Name/Relation		19b. Ma	iling Address (Stree	t and Number or Ru	ıral Route Numb	per, City or Tow	n, State, Zip	Code)
ž	alth a 27 is 27 is r tra		Mr. Bruce A. I	Bennett / Son			oad Glen				
Jre,	of He of He rothe	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State				position (Name of rematory or other pla		. 16,	20c. Location		
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Baltimore,	permit. Departimont import any inj		21. Signature of Funeral Service	Vanur	1001331		Avenue SW		urnie,	1 Hom MD 21	061
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Division	al or Attending F s after death. Il Director: After id in by the funera	ertification:	2 Accident inves		injury - At home, farm etc. (Specify)			28f. Location City or T	(Street and No own, State)	umber or Ru	ral Route Number,

To the Hospital or Attending Physician: The law requires that th within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach

cal Examir	cause. Disease or injury that initiated events resulting in death) Last	c. Quinquel (Due to (or as a consequence of):	leme	er extr	inelië,		iv letter
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To Be	examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3[	3 DOA Other: 4 Nursing Home 5 Residence 6 □Other (S)			e 6 ∐Other (Sp	pecify)
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Me	29b. Signature and title of certifier	Ramenez News		cense number	2	Date signed (Mo	onth, Day, Year)
		completed cause of death (Item 23a) (Type, Print)	1 78	to Dake	vord Rd	4 200	
		RAMIREZ M.D		len Bu	nie M	2106	
		1 6 11 1 2: 11 1	7				,

P State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SALVALON D. PAM (NET M.)

31. Date filed (Month, Day, Year)

DEC 1 5 2006

33 Registrar's Signature

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	Funeral Director		219 09 2500	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Months	1 Year Days	If Under 24 Hrs Hours Min	. (Mont	of Birth h, Day, Year 20, 1	) C	thplace (State or Foreign buntry) ryland
	Maryland f ehow	ō	Usual Residence of Decedent     10a. State   10b. County		ity, Town or Lo							10d. Inside City Limits 1 🖾 Yes 2 🗆 No
	a or 28a-	Direct	10e. Street and Number 3812 Penningtor			10f. Zip	Code 212	 26		10g. C	itizen of What Co	puntry?
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	and 2 shi leelth and m 27 is m		19a. Informant's Name/Relationship (Ty Wayne Borkoski /	son	5521	Weywo	od D		Reis	terst		yland 21136
Baltimore,	permit. Pages 1 Depertment of F Important: If ite eny injury or of once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ② Other (Specify)	emoval from State Entombment Co	Place of Dispose cometery, cremetery, cremetery	natory or oth 11 Cen	her place netei	cy 12/	Date 16/200	6 Bal		Maryland
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ion of	Attending Phy r death: •ctor: After this by the funeral c	<b>⊢</b> ‡	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		c. Injury			ribe how inju	6 ☐ Other (Spering occurred	ony)
Divis	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At a building, etc. (Special Control of the	nome, farm, stre	eet, factory,	office		28f. Locati City o	on (Street air Town, State	nd Number or Ru e)	iral Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	edicai	one) 2 Medical Exami	vician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at restigation, i	t the time in my opi	e, date and place nion, death occu	e, and due to urred at the ti	the cause(s me, date an	) and manner as d place, and due	stated. to the cause(s)
	To T Com	Σ	29b. Signature and title of certifier	11 0		29c.	License	number		29d. Da	ite signed (Monti	h. Day, Year)
	3		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, I	Print)	VOC			DE	CEMISE	=14,2006
	Star Registra	_	ADDISU MENG 31. Date filed (Month, Day, Year) DEC 1 5 20	32/Registrar's Sign	DI SOL	TH H	ANC	OVER '	ST., 6	ALTII	10RE,	MD,21225

			1 For State	State of Maryland	/ Department of Health and	Mental Hygien	enna 39965
			Registrar  1. Decedent's Name (First, Middle	Lasti	Certificate of Death	Reg. N	
	Physic		Tames	Branch		Month D.	ay Yeer 0240 M
	/Medi Exami		4a. Facility Name (If not institution,	give street and number)	4b. City, Town, or Location of Deal	December th 4	c. County of peath
7			5. Social Security Number	maritan Ito	Sp. Batmor st birthday) If Under 1 Year If Under 24 Hrs		N/A
	Funeral Director		218-44-2283	6. Sex 7. Age (In yrs. la	Yrs. Months Days Hours Min		9. Birthplace (State or Foreign Country)
	and		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Location	septra,	119 Maryana
	Maryla	to	MIN	I/A D	Latimore		10d. Inside City Limits 1 28 Yes 2 □ No
	ours after death with the Marylan et', or Items 23a or 28a-f show Examinar mual be notified at	Funeral Director	10e. Street and Number	11.0	101. Zip Code	10g. C	itizen of What Country?
	sath w	ral	5004 Frai	aktord Av	e, 21206		USA
က	of them	Fun	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in U.S Armed Forces? 1  Yes 2 No	. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
21215-0036	hours after death with the Maryland turel, or Items 23a or 28a-f show all Examinat must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Black
15-	72 E H	olete	15. Decedent (Specify only highest	grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo	rking 16b. H	Kind of Business/Industry
212	d within giene. er then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Home Improvo	mont	Private
	be filed htal Hyg od othe event,	Be	17. Father's Name (First, Middle, L	ast)	8. Mother's Na	me (First, Middle, Maide	Sumame)
Maryland	s t and 2 should be f Health and Mental item 27 is marked other traumatic ev	2	19a, Informant's Name/Relationsh	or (Type, Print) (daughter)	19b. Mailing Address (Street and Number or Ri	C GIII	im Branch
	and 2 salth ar n 27 is		Ms. Kimber	y Branch	5632 Pinneer	Drive B	1 Ho Md. 21214
ore			20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation		ce of Disposition (Name of netery, crematory or other place)		ocation - City or Town, State
Baltimore	Pa ne ne ne ne ne ne ne ne ne ne ne ne ne		4 □ Donation 5 □ Other (Sp 21. SignatOne of Funeral Service)	ecity)	inity Cemetery d/	18/2006 D	undalk, Md.
Ba	permit. Depertrimports eny inju		▶ Carenh	L' KUM	22. Name and Address of Eacility Joseph L. Russ	Funeral	Home, P.A. Md. 21216
	/ks		23a. Part Enter the disease, or o shock, or heart failure. List o	complications that caused the death, may one cause on each line.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a. Coronam	Arden Disease		Onset and Death
	Examiner			Due to (or as a conseque			
	© €.	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseque	1 . 1		
/	end end I-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseque	es Mellitus		
8760	e be e /sicien e buria	cal E		d	100 or).		
9	ntificat ng phy s as the		IF FEMALE:	0.			
Вох	w requires thet the death certificate be executed been signed by the attending physicien end should be detached for use as the buriat-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnance	eath 3 ☐Ectopic pregnancy		23d. Date of delivery  Month Day Year
	the de	hysic	1 ☐ Yes 2 Ø No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐ Unknown	th 5 Other (specify)		Month Day 18a1
	The law requires thet the let has been signed by the bage 2 should be detache	by PI	Part II. Other significant condition	s contributing to death but not resulti	ing in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ord	requir een si hould l	ted				1 🗆 Yes 2	□ No 3 Probably 4 □Unknown
Rec	a S C	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of
ta	ysician: The lis certificate hadrector, page	a)	25. Was case referred to medical		26 Place of Dec	1 ☐ Yes 2 ☑ No	death? 1 ☐ Yes 2 ☑ No
Ž	Physici this cer al direc	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 EF	04	ome 5 Residence	6 □Other (Specify)
Division of Vital Records,	Attending Physician: r death. ector: After this certifice by the funeral director, p		27. Manner of Death 1   Natural 5   Pending	(Month, Day Year)	8b. Time of 28c. Injury at Work?	28d. Describe how injur	
/isi	Attender death	ficat	2 Accident investiga 3 Suicide 6 Could no	t be 28e. Place of Injury - At home	M 1 Yes 2 No	28f. Location (Street an	nd Number or Rural Route Number,
ă	rs afte al Dire	Certification:	4 Homicide determin	building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, State	i)
	To the Mospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying (Check only one)	xaminer: On the basis of examination	edge, death occurred at the time, date and place n and/or investigation, in my opinion, death occu	, and due to the cause(s)	and manner as stated.  I place, and due to the cause(s)
	ro the within 3 Fo the somple	Med	29b. Signature and title of certifier	and manner stated.	29c. License number		te signed (Month, Dey, Year)
	. , , ,		► / // €	Lawrence n	10 D51148	Des	embe 14 2006
	3		200. 7 1	ho completed cause of death (Item 2)			
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signatur		Girnore MO	21217
ক্	Registr		DEC 15	2006 R	hogel o		
DH	MH 17 Rev 1/20	001		Janes 15	Jan 18		

		-	1-	For State	S	tate of Mary	/land /		tment of H			giene Reg. No.	006	39966
			1. D	Registrar ecedent's Name (First, Mide	fle, Last)						2. Date of De	ath		3. Time of Death
	Physicia	in		Loron		Brac	llei	J .	Tr		Decem	Day	9 2006	5 11:30 AM
4.0	/Medic Examin		4a. I	ecility Name (If not instituti	on, give stre				4b. City, Town, or	Location of Death			County of Deat	i
			-	Vorthwes	T He	-	Cent	_	Kando	Ilston	n	18		nove
	Funeral		5. S	ocial Security Number	6. Sex	7. Age (I	n yrs. last j	birthday)	If Under 1 Year Months Days	'If Under 24 Hrs. Hours Min.	8. Date of Bin Month, Da AU4, 2	h Y Year	9. Birt	hplace (State or Foreign untry)
	Director	4		4-56-5384 al Residence of Decedent	)	5	0	115.			Aug. 2	8,172	DU IVI	ary rana
	land ow			. State 10b. Coun	У /	16	Oc. City, T	own or Loca	ation					10d. Inside City Limits
	Mary Fig.	ģ	1	Ad. I	VIA		B	alt	more					1 Yes 2 No
	or 28	irec	10e	. Street and Number	/	/ 1			10f. Zip Code			10g. Citiz	en of What Co	untry?
	23e c	aiD	3	121 St.	Luk	es Lo	ine		2/3	207			USI	
	tems terms	Funeral Director		Marital Status		Was Decedent Eve Armed Forces?	er in U.S.	13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	.   '	<ol> <li>Race - Ame Black, White</li> </ol>	
36	hours after death with the Maryland turet, or Items 23e or 28e-f ehow al Examiner ouat be notified at			1 ☐ Never Married 2 ☐ Mi 3 ☐ Widowed 4 ☐ Divorce		1 Yes 2 No If Yes, Give Year or Dates:		1	□Yes 2DXNo	Specify:			Specify: B	lack
Ş	P hou	ed		15. Decede	ent's Educati	ion	1	6a. Decede	nt's Usual Occup	pation during most of work	ina	16b. Kin	d of Business/	Industry
21215-0036	I within 72 hours after death with the Marylan ilene. Than *natural; or liems 23e or 28e-f show the Madical Examiner count be notified at	Completed by	E	(Specify only high lementary/Secondary (0-12		College (1-4or 5+)		life. D	O NOT use retired	d) A	ing i	D.	1.1	01-110
21	filed with Hygiene. Ither the	Con		12		2		eac	ner's	18. Mother's Nam	Tant Office Middle	000	ra ut	Child Care
ğ	\$ g a \$	Be	17. j	Father's Name (First, Middl	e, Lasi)	1100	Ca			EL. 7	( L of	/	MARC	chall
Maryland	d 2 should be th and Mental 7 le marked o traumatic eve	ဥ	19:	a. Informant's ame/Relatio	nship (Type	Print) (1)	tel	19b. Mailing	Address (Street	and Number or Ru	ral Route Numb	er, City or	Town, State, 2	Zip Code)
Ma	12 P P P P P P P P P P P P P P P P P P P		Ň	re Turni	+	Bradle		215	15+1	ukes	Lano	R	alto.1	Md.21207
ē,	s t and f Healt ltem 2		20a	. Method of Disposition			20b. Plac	e of Dispos	ition (Name of atory or other pla	ce) In I	Date	20c. Lo	cation - City or	
E	0 0 = =			1 Burial 2 □ Crematio 4 □ Donation 5 □ Other		ioval from State	Kir	a Me	emorial	Park 1241	5/2006	B	alto.	Md.
Baltimore	permit. Pag Department Important: eny Injury o		21	Signature of Funeral Service	Licensee	DID		-	Name and Addre	ess of Facility	Finos	alt	tome.	P.A.
<u> </u>	89559			· Joseph	VX	· Bu	2	22	22 W.	Vorth A	tre.	Ba	To M	1.21216
				a. Parti Enter the disease, shock, or heart failure. L	or complical ist only one	tions that <del>cause</del> d the cause on each line.	e death.	Do not ente	r the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
100	Physician		dis	mediate Cause (Final sease or condition sulting in death)	a	Cor	ONO	1V1	arter	y D3	ease			Years
1	/Medical Examiner		10.	sutting in Geattry		Due to (or as a d	onsequer	JCB 01	cion	1				Yeare
		er	Se if a	quentially list conditions, my, leading to immediate	b	Due to (or as a	posequer	nce of):	SION	0				· corres
1	d ansit	Examiner	Ca	use. Enter Underlying use (Disease or injury at initiated events	1									
0,0	en an		res	sulting in death) Last		Due to (or as a	consequer	nce of):						
8760	The law requires that the death certificate be executed ate has been signed by the attanding physicien and page 2 should be detached for use as the burial-transit	dical			d									
x 68	leath certifica attanding ph	/Med		FEMALE:	230	. If yes, outcome of	pregnanc	:v					23d. Date of de	livery
Вох	attan for us	Physician/M	23	b. Was decedent pregnant in the past 12 months?		1 Live birth 2 4 Pregnant at tir	☐ Fetal de	eath 3 🗌	Ectopic pregnand Other (specify) _	y			Month	Day Year
P.O.	that the de ned by the a detachad t	ysi		1 Yes 2 No 9 Unknown		9☐ Unknown								
	res that igned b	by PI	Pa	rt II. Other significant cond	itions contr	buting to death but	not resulti	ing in the un	derlying cause gr	ven in Part I.				the cause of death?
ğ	w require been sig should b	ed	-								10	Yes 2[	]No 3∏P	robably 4 Tunknown
Records,	law re as be 2 sho	Completed	_								24a. Was	DSV	24b. Were a prior to	utopsy findings available completion of cause of
	The ate h page	Con									1 ☐ Yes	ormed? No	death? 1 ☐ Yes	2 □ No
/ita	iclen: sertific ector,	Be	25	. Was case referred to med examiner?		spital:			Ot	26. Place of Dea				
of Vital	Phys this ral dir	7.	27	1 ☐ Yes 2 ☐ No		28a. Date of Injury	2	R/Outpatient 8b. Time of	3 DOA 28c. Inju	4 🗆 Nursing r	ome 5 Res			ecify)
o	ding th. After	tion	-	1 ☑Natural 5 ☐ Per	ding stigation	(Month, Day	Year)	Injury		ork? ]Yes 2∐No				
Division	Attendes cotor	ifica		3 ☐ Suicide 6 ☐ Cou	ild not be	28e. Place of Injury	y - At hom	e, farm, stre	et, factory, office			(Street an wn, State		ural Route Number,
ā	tal or s afte al Dir ed in	Certification:		4   Homicide		Dulldurg, old.	(0,000,1)							
	To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: Alier this certificate has completely filled in by the funeral director, page 2.	edicai	29	(Check only 2 Media	ying Physic al Examine	ian: To the best of ir: On the basis of e	xaminatio	ledge, death in and/or inv	occurred at the trestigation, in my	ime, date and place opinion, death occu	e, and due to the irred at the time	cause(s) , date and	and manner a I place, and du	s stated. e to the cause(s)
	thin 2, the f	Med	20	one)  b. Signature and title of cer	ifier	and manner state	ed.		29c. Licen	se number		29d. Dat	e signed (Mon	th, Day, Year)
	T X T 8			MMON					75	6418		Do	ombo	v 9,2006
	5		30	). Name and address of pers	<u> </u>	pleted cause of dea	ath (Item 2	23a) (Type,				بالمز		9-1000
				K-Tonya	Maso	N 5401	01	d Co	urt Roc	ad, Rand	allsto	wn	MD =	11133
		ate	3	1. Date filed (Month) Day, Yo		32 Registrar	's Signatu	гө		·				
	Regist	rar		DEU 1	5 2006	1 Dage	1.	100	257 9					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** lifford DECEMBER By B. £3/26 Cook /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Medical Saint Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**\** M 2□ F Months Days Hours Min. 213-60-099 10,1948 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Baltimore ocheysville Ud 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or Items 23a or event, the Medical Examiner must be r 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 N If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 No Specify Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than "r. r traumatic event \*\* College (1-4or 5+) Elementary/Secondary (0-12) Porter heeltu 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) : 1 and 2 should be fill Health and Mental H tem 27 is marked ott Be UNK. ပ OOK harlotte 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Arm GLEN Arm Ad permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr. inarlotte 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State M+ZION AME Church Cem 12/18/06 Long Green

1 22. Name and Address of Facility Chatman - Harris Funeral 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 5240 Preisterstown Bd Tres Baltimore 23a. Part1. En or the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart fail re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PNEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transi Due to (or as a consequence of): physician the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a detached f 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ANOXIC ENCEPHALOPATHY 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 autopsy certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To After this 28a. Date of Injury (Month, Day funeral 27. Manner of \_eath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending 1 Natural 2 Accident 5 ☐ Pending investigation Year) 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12-08-06 D0030263 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MARYLAND 21204 7601 OSLER DRIVE FRANCIS KHOO. M. D.

State Registrar

2006

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Maryland 21215-0036

3altimore,

Division or Vital Records, P.O. Box 68760

				1 - For State of Maryland / Dep	eartment of Health and Mertificate of Death		giene 006 39968
	J.	Dbi-i-i		1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	Day Year
		Physicia /Medic		Giuseppe G. Cimino		Decemb	per 13,2006   3:20 p. M
		Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			×,	Oak Crest Care Center  5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday	Parkville  If Under 1 Year If Under 24 Hrs.	8. Date of Birt	Baltimore Co.  h 9. Birthplace (State or Foreign
	3	Funeral Director		5. Social Security Number 173-12-5843 6. Sex 1 7. Age (In yrs. last birthday 1 Yrs. 93 Yrs.	Months Days Hours Min.	(Month, Da	3. 1913 Rosello, Italy
				Usual Residence of Decedent			10d. Inside City Limits
		arylar show	5	10a. State 10b. County 10c. City, Town or L			1 ☐ Yes 2 No
		with the Marylands or 28a-f show	Funeral Director	Maryland Baltimore Co. Parky  10e. Street and Number	/IIIe 10f. Zip Code		10g. Citizen of What Country?
		with Sa or	ā	8832 Walther Blvd.	21234		United States
1		death ms 2:	nera		. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		
3	9	rs after death wil	/Fu	1 Never Married 2 Married 1 M Yes 2 No	1 ☐ Yes 2 ☑ No Specify:	r ricari, etc./	Specify: White
0	5-0036	2 5 1	d by	3 X Widowed 4 Divorced Year or Dates: WWII	edent's Usual Occupation	}	16b. Kind of Business/Industry
0	15-	d within 72 ho piene. r then "natu	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired)	ing	700. Killa of Business/industry
2	2121	d withir giene. r then	шо	Elementary/Secondary (0-12) College (1-4or 5+)	Chief of Security		VA Hospital
	b	2 should be filed within and Mental Hygiene.  Is marked other then aumatic event, the M	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle,	Maiden Sumame)
3	aryland	should b ind Menta marked umatic e	Tof	Carmine Cimino	Concett	, <u>, , , , , , , , , , , , , , , , , , </u>	mino
	Mar	d 2 should th and Men 7 Is marke traumatic		To April Horsen De Septembre de Conse	ling Address (Street and Number or Rui		ON THE RESIDENCE OF A SECURIOR
9)		lead Head		20a Method of Disposition 20b. Place of Disp	204 Chenoak Court	Baltimo Date	21234 20c. Location - City or Town, State
pp	Baltimore,	permit. Pages 1 Department of H Important: if Ite eny injury or ot		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Mom Dank 12/16	5/2006	Paltimono Manuland
0	Ħ	nit. P aartme oortan injur		Tiorcrane	Mem. Park 12/16 22. Name and Address of Facility	100000000000000000000000000000000000000	Baltimore, Maryland 5305 Harford Road
26	B	Ded of the color		MICHAEL E. Canapp	Leonard J. Ruck.		Baltimore, MD 21214
5				23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory ai	Interval between
		Physician		fmmediate Cause (Final disease or condition as Physical P	a		Onset and Death
(		/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
•	€.	瀛 太正	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
o	0.	uted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.			
50	J	be executed iician and burial-transit		resulting in death) Last Due to (or as a consequence of):			
تح	3760	0 % 0	Ical	d			
	к 68	certifica Iding ph	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			
U	Вох	ires that the death certificat signed by the attending phy d be detached for use as th	Physician/Med	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Year
^	o.	the de y the	nysk	1 Yes 2 No 9 Unknown			
9	٦,	requires that the death een signed by the atter hould be detached for u	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did t	obacco use contribute to the cause of death?
00	rds	w require been sig should b	edt	Consestive heart tailure		10	Yes 2 No 3 Probably 4 ™nknown
l.	Records,	≥ □ 0	Completed			24a. Was	osy prior to completion of cause of
N	= H	The laste has page	Con			1 Yes	ormed? death? 2 → No 1 → Yes 2 → No
1	of Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Dea		
3	<del>j</del> o	Phys rthis ral du	1. To	27. Manne of Death 28a. Date of Injury 28b. Time	of 28c. Injury at		dence 6 ☐Other (Specify) how injury occurred
	on	Attending Firdeath.  Cotor: After by the funer	atlor	1 Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
1	Division	r Attendii er death. rector: A i by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 4 ☐ Homicide 28e. Place of finjury - At home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (: City or Tox	Street and Number or Rural Route Number, wn, State)
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		To the Hospital or Attanding Physician: The lawithin 24 hours after death To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier  (Check only one)    One   Check only one   Check one   C	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the red at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
		To th within To th	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
				A C-MO	061785		12/13/2006
	e Commo	6		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	D.	11. 40 71774
				C D5 hQ D X on MD 8800 ( 31, Date filed (Month, Day, Year) 32// Registrar's Signature	walther Boulevard	rark	whe MU 4239
		Sta Regist	ate rar	DEC 1 5 2006	and a		12/13/2006 Wille, MD 21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5&19a State of Maryland/Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day ETHEL L. CONLEY- RAMSEUR PM 2006 3:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STEUA MARIS TIMONIUM BALTIMORE If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number LNK 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 M F 246-34-8125 Director 81 Yrs. 04.15.1925 ÑC Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or Items 23a or 28a-f show any Injury or other traumatic event, tra Medical Examinat must be notified at ones. 10d. Inside City Limits Funeral Director mo 1 Yes 2 No BALTIMORE MALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11757 CT. 20601 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK Specify: Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOME MAKER 10 TH BRADE NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRISON N. CONLEY MATTIE NORMOOD 19a Bedriay's McClienniss (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETY M'GINMS (SISTER DR. CLEVELAND 3970 WENDY OH Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 12.14-06 GREENMOUNT BALTO . MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MO 21. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Day Year 4☐ Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown been ( 24b. Were autopsy findings available prior to completion of cause of death? hes autopsy performed? certificate 1□ Yes 2X No of Vital 1 Yes 2 No Hospital or Attending Physician: After this certifice funeral director, I Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HUSPICE 2 1 ☐ Yes 2X No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funerel Dire Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 22. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

DEC 1 5 2006

DECEMBER

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** 2:25 A M 2006 DEC 12 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA AGNES HOSPITAL BALTIMORE SAINT 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Days **Funeral** Hours Months 1 ☐ M 2 X F 212-48-162 Director Usual Residence of Decedent or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 □ No more NA Director 10g. Citizen of What Country? alaa7 by Funeral Pages 1 and 2 should be filed within 72 hours after death Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 21 No 1 ☐ Never Married 2 ☐ Married ☐ Yes 1 ☐ Yes 2 ☐ No altimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Year or Dates: Completed Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical in once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use rejired) nd Mental Hygiene. marked other than College (1-4or 5+) N ath Be ( h and Mental h ၉ Health a Wother 1 ABurial 2 □ Cremation 3 Removal from State 5 ☐ Other (Specify) 4 Donation f Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK Physician DAYS /Medical Due to (or as a consequence of): Examiner CARCINOMA YEARS METASTATIC BREAST Se juentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Month Year Day 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a d be detached for 9□Unknown 9 Unknown SAUNDRA 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2X No To the Funeral Director: After this certificate I within 24 hours alor Director: After this certificate I womeletely filled in by the funeral director, pag 1∐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 2 ER/Outpatient 3 DOA 1 Inpatient 2 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 □ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P19925 Punnam, Dec, 12,2006

Registrar

State

900 S. CATON AVENUE

32. Registrar's Signature

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PUNNAM

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** John W. Coffin Year December 13 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sykesville Fairhaven Health Center Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 € M 2 □ F Yrs Director 005-14-0169 Dec 2 1915 Maine Usual Residence of Decedent the Maryland 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at Svkesville MD Carroll Director YOYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21784 USA 7200 Third Avenue C - 112or Itame 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. snt: If Itam 27 is marked other than "natural", or Ital Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No δ Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) auto technician automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Coffin Hazel Sharpe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Itam 27 is any injury or other tra Miriam H. Coffin (spouse) 7200 Third Ave., C-112, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD All County Cremation 12-14-06 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee ▶ (Parge spaight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pheumonia **Physician** disease or condition resulting in death) day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, 1 any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine physicien and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical anding p IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery atter for L 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 1 No 1 🗆 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No ဥ 1 Inpatient 2 ER/Outpatient 3□ DOA this After thi 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation completely filled in by the 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide within 24 hours a To the Funaral [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time. Medical 29a Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of Certifier 29d. Date signed (Month, Day, Year) December 13 200% 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Tau MD 1645 Air Road Eldershung MD 21784 Liberty 10 William 194 31. Date filed (Month, Day, -Year) 32. Regiştrar's Signature State 5 Registrar

			1 - For State Registrar	State of Marylar		artment rtificate			and M		iene	006	39972
	Physici	an	Decedent's Name (First, Middle, Last,				-			2. Date of Death	Day	Year	3. Time of Death
	/Medi	cal		COACHMAN						12	7	2006	5:00 PM
	Examir	ner	4a. Facility Name (If not institution, give		SING	4b. City, To		Location of		RE		ounty of Death	RE CITY
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs.	erk_	If Under 1	Year	If Under 2	24 Hrs.	8. Date of Birth			
	Director		577 <b>-</b> 22-9197	M 211 92	Yrs.	Months	Days	Hours	Min.	(Month, Day, 06-09-1	<sup>Year)</sup> 914	Coun	lace (State or Foreign htry) VA
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Baltimore,	# # <b>#</b> # .	l	21. Signatule of Funeral Service Lice		1 -	. Name and				. F. Bel	L1 Fu	ineral H	Home
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Ĭ L	The law ate hes be	E								autopsy performe	ed?	prior to com death?	pletion of cause of
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<u>&gt;</u>	hysic his ce I dire	10	1 ☐ Yes 2 ☒ No	ospital: 1   Inpatient 2	ER/Outpatient	3□ DOA	Other			ne 5 ☐ Residen		Other (Specify)	)
5	nding P nth. r: After t e funera	atlon:	27. Manner of Death 1 ⊠ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury a Work? 1 ☐ Ye	at es 2 ∐N		8d. Describe how	injury oc	curred	
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2 or	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	et, factory, o	ffice		2	8f. Location (Stre City or Town,	et and Ni State)	umber or Rural	Route Number,
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			A acecon	of certification	VII) IVE I	1	00	061	27	2	12	. 9. 2	006
	5		29b. Signature and title of certifier  A CLEECLU  30. Name a address of person who co	RHAM, M.D	n 23a) (Type, F	Print)	5.	AMI	RIT	TAN N	URS	ING 4	IOME.
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture								

DHMH 17 Rev 1/2001

06-09460 Theodore Dominic	que	Please Type Caldwell Stat	or Print in Blace of Maryland /	ack Indeli Departme	<b>ble Ink.</b> ent of He	Ensure All C	opies Are L	egible.		
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Physician Medical Examine	er	1. Decedent's Name (First, Middle, L Theodore	e Domi	inique	С	aldwell	2. Date of D Month Decemb	eath Day Year Der 11, 2006	3. Time of Death 1759 hrs	
		4a. Facility Name (if not institution, University Hospital	give street and number)			y, Town, or Location o Itimore	f Death	4c. County of Dea	ath	
Funeral Director		272 06 6202	Sex 7. Age  X M 2 F	(In yrs. last birth		nder 1 Year If Unde nths Days Hours	Min.		Birthplace (State or eign Country)	
the Maryland a or 28a-f show any difed at once.		Usual Residence of Decedent  10a State  10b County  Md.  Baltin  10e Street and Number  4739 Buxton Circ		Owin	gs Mil	ls Zip Code 21117		10g. Citizen of What Co	10d. Inside City Limits 1 Yes 2 X No	
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imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene taut: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		Elementary/Secondary (0-12) College (1-4 or 5+)  11th grade  17. Father's Name (First, Middle, Last)  College (1-4 or 5+)  Self-employed  Car  18. Mother's Name (First, Middle, Maiden Surnal							1	
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Baltimore, I permit. Pages I and Department of Healt Important: If trem injury or other tra		20a. Method of Disposition  1 X Burial 2 Cremation  4 Donation 5 Other Spec  21 Signature of Funeral Service Lic	ify:	e cremato	Mem. Pi	srk nd Address of Facility	12-16-06  March I Ave., Ba	Randalls F.H. East ltimore, Md.	stown, Md.	
Physician /Medical Examiner	1	23a Part I. Enter the disease, or co failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	mplications that caused t each line. a Multiple Gunshot Due to (or as a consec	t Wounds	enter the mod	de of dying, such as ca	rdiac or respiratory a	arrest, shock, or heart	Approximate Interval Between Onset and Death	
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of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed that certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial - train. To Bo Completed by Dhysician Modical	2	F FEMALE: 3b Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkno	23c. if yes, outcom  1 Live birth  4 Pregnant at ti  9 Unknown	2	Fetal dea		pregnancy	23d Date of delive Month	pry Day Year	
P.O. res that the signed by be detach	3	Part II. Other significant condition	s contributing to death	but not resulting	in the underly	ing cause given in Par		tobacco use contribute to		
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ician: certifi rector,		25. Was case referred to medical examiner?	Hospital:			26 Place of Death (0				
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Division o Hospital or Attending 24 hours after death ethy filled in by the fune	בוווכמו	2 Accident Investig 3 Suicide 6 Could n 4 Homicide	ot be Dec 11, 2006  28e. Place of Inju			ory, office building, etc.	28f. Location or Town,	(Street and Number or R State) North Avenue , Baltime		
P. Hospi 24 hou Funer etely fil	- 4	On Cortifion			h occurred at	the time, date and plac		use(s) and manner as sta		

Registrar

State

and manner stated.

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who concleted cause of death (Item 23a)

Susan Hogan MD.

31. Date filed (Month Pay, Year) 5 2006

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

December 12, 2006

			State of Maryland / D  State of Maryland / D  Registrar	epartment of He Certificate of D			ene g. No. 2 N (	16 39971		
*	Physicia	an	1. Decedent's Name (First, Middle, Last)  Martha  E.	Clary		2. Date of Death Decembe	r Day 2,200	3. Time of Death 6 12:30A M		
	/Medic Examin	400	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or I	Location of Death		4c. County of I	Death		
			Crofton Convalescent Center	Crofton			Anne A			
1	Funeral Director		210-22-90/3	hday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, May 28	Year) 9. • 1926	Birthplace (State or Foreign Country)  KY		
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits		
	Maryla f sho led at	jo	MD Anne Arundel Mille	ersville				1 ☐ Yes 21 No		
	r 28a- notif	rec	10e. Street and Number	10f. Zip Code		10	g. Citizen of Wha	t Country?		
	th with	a D	479 Brightwood Road	21108		ı	J.S.A.			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If them 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☒ No  If Yes, Give  Year or Dates:	13. Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2☒ No	spanic Origin? (Spen, Mexican, Puerto Specify:		14. Race -	American Indian, White, etc. white		
8	2 hour	edt	15. Decedent's Education 16a.	Decedent's Usual Occupa	ition		6b. Kind of Busin	ess/Industry		
Maryland 21215-0036	thin 72 e. an "na Medio	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done du life. DO NOT use retired)	uring most of worki	ng				
21	ed wit ygien ier th	Sol	8 Wa	itress				ervices		
gug	be fill ntal H ed oth even	Be	17. Father's Name (First, Middle, Last) Clarence Wilson Taylor		18. Mother's Name	e (First, Middle, M Le (unkno	,			
Z 2	hould d Mer marke matic	2	· · · · · · · · · · · · · · · · · · ·	Mailing Address (Street a				to Zin Code)		
Ma	nd 2 s Ith an 27 is i			9 Brightwood						
<u>6</u>	s 1 ar f Hea ltem other		20a. Method of Disposition 20b. Place of	Disposition (Name of y, crematory or other place	-		0c. Location - Cit			
E G	Page nent o nt: If		Exemple   2   Cremation   3   Hemoval from State	Olivet Cem.	i i	5-2006	Baltimo	re, MD		
Baltimore,	rmit. spartn porta y inju		21. Signature of Funeral Service Licensee	22. Name and Address		gleton I	Funeral l	Home, PA		
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			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or neart failure. List only one cause on each line.	ot enter the mode of dying	, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death		
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P.O.	the di y the iched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	5 Other (specify)	***					
σ.	s that ned b e deta	y P	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given	n in Part I.	23e. Did tob	acco use contribu	te to the cause of death?		
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or \	physi this c al dire	ဥ	1 Yes 25 No Hospital: 1 Inpatient 2 ER/Out		4 Danursing Hol	me 5 Resider		Specify)		
n (	ding Physician: n. After this certific funeral director,	ion	Tadivatulal SElf-ending	jury Work?	at ? ′es 2∐No	28d. Describe how	v injury occurred			
Division or Vital Records,	Attende death death ctor:	licat	3 Suicide 6 Could not be 28e. Place of injury - At home, farm			28f. Location (Str	eet and Number o	r Rural Route Number.		
Ο̈́	tal or / s after al Dire ed in b	Certification:	4 ☐ Homicide determined building, etc. (Specify)			City or Town,	State)	,		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) (Check only one)	death occurred at the time l/or investigation, in my op	e, date and place, a pinion, death occurr	and due to the ca ed at the time, da	use(s) and manne te and place, and	er as stated. due to the cause(s)		
	To th within To th	Me	29b. Signature and title of certifier	29c. License	number	29	d. Date signed (A	fonth, Day, Year)		
			· Della Mi	0389	958	/	2/12/0	6		
	ا ہے		30. Name and address of person who completed cause of death (Item 23a) (1							
	5		Dalet Sunh Sillon MD	208 Crain	Hishwa	, Sw	Clan Bo	mie MD 2/06,		
	Sta Registr		31. Date filed (Month, Day, Year) 32, Registrar's Signature	doorte	V			/		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7:30 P M Mark E. DeMoss 2005 Dec. 13, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 109 Country Lane Timonium Baltimore 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sta Country)

Jan. 31, 1953 Maryland If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1**X** M 2 □ F 53 218-62-1191 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No MD Baltimore Timonium 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 109 Country Lane 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced white white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Vendor MDM Snacks 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis J. DeMoss Melvina Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvina Smith - Mother 109 Country Lane Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Dec. 14, 06 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. P. A. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carrinoma Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24a. Was an Were autopsy findings available prior to completion of cause of autopsy ormed? 2**X** No 1∐ Yes 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

**Physician** /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any in]ury or other traumatic event, the Medical Examiner must be reany in]ury or other traumatic event, the Medical Examiner must be reany in]ury or other traumatic event, the Medical Examiner must be reany in [1].

Maryland 21215-0036

Baltimore.

Director

Funeral

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Physician/Medical

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Certification:

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To the Funeral Director: After t

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Hospital

	25.	Was case r examiner?	eferred	to medica
		1 ☐ Yes	2 No	
١	07	Mannar of F	Sonth	

1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide

28a. Date of Injury (Month, Day Year) Injury 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

	Certifier
ЭД.	Ceruner
١.	(Check only
١.	nnol

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b ignature and title of certifie and address of person wh 3a) (Type, Print)

Year)

29d. Date signed (Month, Dav. Year)

SAMY 31. Date filed (Month, Day,

ESTRICK

3101 Suint Paul St. Balto, MD 21218

State Registrar

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F rtificate of	lealth and M <i>Death</i>		iene2 () (	06	39976
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	/Medio	cal	4a. Facility Name (If not institution, give		M. Dondor		or Location of Death	December	4c. County of	206	1135 "
	Examir	ier	the Memorial	Hospi	4.1		3.Ston		4c. County o	1607	
	Funeral		5. Social Security Number 6. Sex	Age	(In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)		e (State or Foreign
	Director		214 15 0521	]м 2√Д F   86	5 Yrs.	Worth's Day's		Feb. 27,		Maryl	
	anyland show		Usuat Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d.	Inside City Limits
	a Man	tor	Maryland Talbo	ot		East	on				1 ☐ Yes 2X No
	ours after death with the Maryla rai' or Items 23a or 28a-1 shov Examiner must be myllind at	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	nat Country	?
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5-0036	ours a	þ	3€XWidowed 4 □ Divorced .	If Yes, Give Year or Dates:		1⊡Yes ¾√xNo	Specify:		Specify:	Wh	ite
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Y N	Menta Menta arked	ToE	Robert F. Smi	th, Sr.				Esther J			
Norf, 7	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Ty)				a <i>nd Number or Rura</i> Ldge Drive			ta <i>te, Zip</i> Co 21601	de)
	F F F F		Phyllis Marsh (1 20a. Method of Disposition	Daughter)	20b. Place of Dispo	osition (Name of			0c. Location - C		State
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.O. Box 68	or Attending Physicien: The law requires that the death certificate be executed fifer death.  Sirector: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Month	,	y Year
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ital	icien: 'certifica	BeC	25. Was case referred to medical	)	Cooge		26. Place of Death	1 Yes 25	231	Yes 24C	No -
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Š	tending Physicien: leath. tor: After this certific the funeral director.	Elon:	27. Manner of Death  1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Worl	yat k? Yes 2 ⊡No	28d. Describe how	v injury occurred		
Visi	Attendi	Hica	3 Suicide 6 Could not be	28e. Place of Inju	ry - At home, farm, str			28f. Location (Stre	et and Number	or Rural Ro	oute Number,
Ö	oitel or urs afte aral Dir	Cert	4   Hornicide	building, etc.				City or Town,	,		
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	ledical Certification:	29a. Certifier Check only one)	er: On the best of and manner stat	f my knowledge, death examination and/or inved.	vestigation, in my o	oinion, death occurre	and due to the cau ed at the time, dat	ise(s) and mann e and place, and	er as stated d due to the	d. cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. License			d. Date signed (i		
			TO HE G	> M			92t	12	2, 11, 2	200	6
	C		30. Name and address of person who con	ripleted cause of de	atn (Item 23a) (Type,	Print) 12	SO TO	ATNO M. W.	n 31	MM	re CTN
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	edi)			- 01		1'
	Registra	:17	5 F A T 9 CO	OU JUNEAU	- 0-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fb 862 12-26-06 yt State of Maryland? Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 3:40 PM DIPLETRO AURA DECEMBER 11 9000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIHORE
If Under 1 Year | If Under 24 Hrs. MO JOHNS HOPKINS BAYVIEW HEDICAL CENTER N/A 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, Year) **Funeral** 012-24-6537 Months Days Hours 1 M 2 F Min 78 Director Aug. 28,1928 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 10d. Inside City Limits Dundalk 1 ☐ Yes 2X No Directo Baltimore Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ms 23a or United States 21222 Funeral <u>2504 West Woodwell Road</u> tral", or items 2 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ð 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Years Homemaker 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James MacLoed Laura Hatt 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Laura C. Maines (Daughter) 2504 West Woodwell Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or c 1 Burial 2 ☐ Cremation 3 ☐ Removal from State □Donation 5 □ Other (Specify) Hill Mem. Gdns. 12/15/2006 Middle River, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Parl I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATIC BLADDER CANCER ONE YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-trai Due to (or as a consequence of) The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Ho 24a. Was an s certificate has the irector, page 2 s autopsy performe 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ours after death.

neral Director; After this filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Division or Vital Records, P.O. Box 68760, within 24 hours a

To the Funeral I

completely filled

Chessa Jalkar Housin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

HARRIS VANESSA JOHNS HOPKINS BAYVIEW 4940 EASTERN AVE BALTIMORE HD 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) DEC 1 5 2006

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

DECEMBER 11, 2006

0

State

Registrar

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 39979 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 6:15 PM M 2006 Doris Gertrude Derby 12 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Victorian Estate Assisted Living Bel Air
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Days 1 ☐ M 2 💢 F Months 219-22-4157 11/28/1928 78 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No MD Harford Joppa 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1623 Singer Road U.S.A. 21085 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2 💢 No 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 9 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Raymond Dryden Ethel Yost 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy J. Deweese (daughter) 1623 Singer Road Joppa, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State

Garrison Forest VA Cem. 12/18/2006 Owings Mill, Maryland

11750 Belair Road - Kingsville, Maryland

22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A.

Approximate Interval Betwee Onset and Deal

29d. Date signed (Month, Day, Year)

Pages 1 and 2 should be filed within 72 hours after death with the Maryland orient: If item 27 is marked other than "naturel", or items 23a or 28a-f show Injury or other traumatic event, the Madical Examinar must be notified at JORIS DERBY and Mental Hygiene. Department of Heelth a Important: If Item 27 is any Injury or other tra

**Physician** 

/Medical

Examiner

Completed by Funeral Director

Be

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Licensee

**Funeral** 

Director

**Physician** /Medical Examiner

ettending physicien and I for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed After To the noepure within 24 hours after death.

To the Funerel Director: All

Division of Vital Records, P.O. Box 68760,

shock, or heart failure. List only one cause on each line.												
	Immediate Cause (Final disease or condition	. Iller	Justatic	Vancorest	ic Carrier	Didi	Onset and Death					
	resulting in death)	Due to (or as a conse	quence of):	VALUE	- C Cog Oire	100	10000					
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bDue to (or as a consec	quence of):									
lical Exar	that initiated events resulting in death) Last	c	Due to (or as a consequence of):									
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Feta	If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify) Month									
2	Part II. Other significant conditions	contributing to death but not re-	sulting in the underlying	g cause given in Part I.			o the cause of death? robably 4 □Unknown					
Completed					24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of 2 D No					
Be	25. Was case referred to medical			26. Place of De	eath (Check only one)							
10	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ t	Othor	Home 5 Residence	6 ☐Other (Spe	ocify)					
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how in	ury occurred						
Certific	3 Suicide 6 Could not b	t be ed 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or R City or Town, State)					ural Route Number,					
Ca	29a. Certifier 1 Cartifying Ph (Check only one) 1 Medical Example	nyarcian: To the best of my known in arriver: On the basis of examina	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause curred at the time, date a	s) and manner as	s stated. e to the cause(s)					

Me

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
DEC 1 5 2006

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

			1 - For State Registrar Amend	Items 24a,2	Maryland / De 5,26,27,29	pa e	rtment of H tificate of L	ealth and Me 862, 12/15 Death	ntal Hygie <b>/06dhb</b>	en <b>e</b> () () 6	39980			
	Physici	an	1. Decedent's Name (First, Mi					:	2. Date of Death Month	Day Year	3. Time of Death			
	/Medio	cal	William Henr  4a. Facility Name (If not institu		205)		45 Ch. T		ctober 3	30, 2006	11:20 AM			
	Examir	ier	2101 Fairland		Jet /		4b. City, Town, or Silver	Springs		4c. County of De				
Ī	Funeral Director		5. Social Security Number 217–36–7964	1∭M 2□F	. Age (In yrs. last birthd		If Under 1 Year Months Days	If Under 24 Hrs.	B. Date of Birth (Month, Day, Y NOV 13,	9.8	irthplace (State or Foreign Country) UNK			
Т	and		Usuel Residence of Decedent 10a. State 10b. Cou		10c. City, Town o	r Loc	ation			-	10d. Inside City Limits			
	Marylan f show	tor		ntgomery			Springs				1 ☐ Yes 2√ No			
	h the	irec	10e. Street and Number				10f. Zip Code		10g	. Citizen of What C	Country?			
	23a c	raiD	2101 Fairland	l Road			20	0904		USA				
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be rectified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ N 3 ☐ Widowed 4 ☒ Divord	If Yes, Give	es? K) No		Vas Decedent of His Yes, specify Cubar ☐ Yes 2X No	spanic Origin? (Speci n, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Am Black, Wh Specify:				
5-0	72 h	etec	15. Deced (Specify only hig	dent's Education phest grade completed)	16a. De	ive k	ent's Usual Occupa	tion uring most of working	16	b. Kind of Busines	s/Industry			
121	withlin ene. than	m d	Elementary/Secondary (0-12	2) College (1-4	For 5+)		<i>0 NOT use retired)</i> arpenter			constru	otion			
d 2	Hygie other	Be Co	17. Father's Name (First, Midd	fle, Last)			_	18. Mother's Name (	First, Middle, Ma		CLION			
/lan	uld be Vental rrked c	To B	Theodore Dul	1				Estella Ma	ay Clada	Cladabuck				
Maryland	2 should be filed within and Mental Hygiene. is marked other than sumatic event, the Market and the material and the market an	3	19a. Informant's Name/Relation					nd Number or Rural i						
	1 and fealth im 27 ther tr					-								
Baltimore,	t. Page tment o rtant: If rjury or		Russell E. Dull/brother  2746 17th Avenue Forest Grove, OR 97116  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Wother (Specify) in state  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State  20c. Location - City or Town, State  21. Signature pureral Servic Licensee  22. Name and Address of Facility  State Anatomy Board 655 W. Baltimore Street											
Ba	permi Depar Impou any ir		Jun	2/1/18		Ba	ltimore.	MD 21201			Street			
н				, or complications that cau list only one cause on eac	sed the death. Do not th line.	ente	r the mode of dying	, such as cardiac or i	espiratory arrest	1	Approximate Interval Between Onset and Death			
	Physician /Medical	Ϋ́	Immediate Cause (Final disease or condition resulting in death)		monia, bro as a consequence of):	nc]	hitis,							
	Examiner													
		Jer	Securatively list conditions if any, leading to immediate											
	acuted and transi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. CVA		_								
68760,	lificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or	as a consequence of):									
687	ifficate g phy: as the	edical		0.			·							
.O. Box	The law requires that the death certificate has been signed by the attending rage 2 should be detached for use as	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 Fetal death It at time of death		Ectopic pregnancy Other (specify)			23d. Date of de Month	əlivery Day Year			
rds, P.	w requires that been signed t should be deta	by	Part II. Other significant cond	litions contributing to deat	h but not resulting in the	e uno	derlying cause giver	n in Part I.			to the cause of death?  Probably 4 □Unknown			
Vital Records,		Completed							24a. Was an autopsy performed	d? prior to death?	utopsy findings available completion of cause of s 2 \( \sum \) No			
Zi:	Physician: Th this certificate al director, pag	Be c	25. Was case referred to medi examiner?	Hospital:			Other	26. Place of Death (						
ō	Phys or this oral di	); To	1 ☐ Yes 2 🛣No 27. Manner of Death	28a. Date of I		e of	28c. Injury	at 28	5 Residence  Describe how		ecify)			
ion	ittending l death. ctor: Alter y the funer	ation	1 Natural 5 ☐ Pen 2 ☐ Accident inve	ding (Month, estigation	Day Year) Injur	У	Work? M 1 □ Y	? es 2 □ No						
Division of	200	Certification;		emined 28e. Place of building,	Injury - At home, farm, , etc. <i>(Specify)</i>	stree	et, factory, office	28	Location (Stree City or Town, S	et and Number or R State)	Rural Route Number,			
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	Medical (	29a. Certifier 1 Certification (Check only one)	ying Physicien: To the be el Examiner: On the basi and manner	s of examination and/or	ath o	occurred at the time estigation, in my opi	o, date and place, and nion, death occurred	due to the caus at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)			
	To the within 2. To the complet	Ž	29b. Signature and title of cert	ifier			29c. License	number		Date signed (Mon	th, Day, Year)			
			<b>)</b>	Unles			D000	54578	1	0/30/0	6			
			30. Name and address of personal Archmoda	Natem			( ^	INGS,	mD	1				
	Sta Registr		31. Date file Houth, Pay, Ye	2006 32. Regi	istrar's Signature	The same	,	/						

06-09426

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jonathan A. Dikoff State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DIKOFF ANDREW JONATHAN 1830 hrs Medical Examiner December 10, 2006 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 100 S. Frederick Street Baltimore N/A 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of **Funeral** Foreign Country) Months Days Hours Min. Director 218-66-1229 47 11/30/1959 MD 1 X M 2 Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d Inside City Limits UNKNOWN Yes 2 No UNKNOWN 28a-f show MD death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country notified at UNKNOWN UNKNOWN USA 23я Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black Armed Forces' White, etc. 1 X Never Married 2 Married 2 X No WHITE permit Pages I and 2 should be filled within 72 hours after. Department of Health and Mental Hygten. Interpretair: I filem 27 is marked other than "natural", o injury or other traumatic event, the Medical Examinter. Yes 2 X No specify. If Yes, Give Year Widowed Divorced Specify ₽ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Complei Baltimore. MD 21215-0036 **SERVER** F00D 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) DIKOFF JANE **FREY** NEWTON Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print ) JANE DIKOFF / MOTHER 9804 SOUTHALL ROAD - RANDALLSTOWN, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEM 12/14/2006 REISTERSTOWN, MD Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 he disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician List only one cause on each line Between Onset and /Medical Death Multiple injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical X UNPENDED AMENDED #23a,27,28a-f perME, g862,12/21/06 TT Box 68760, IF FEMALE 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death Month Year past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. by ( Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' page ✓ Yes 2 No After this certificate 1 V Yes 26. Place of Death (Check only one) Fo the Hospital or Attending Physician: 25 Was case referred to medical Be Other<sub>4</sub> Hospital: 1 Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 V Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification; Natural 1 Yes 2 X No 5 Pending death. the 12/10/2006 6:29 pm subject jumped from height 2 Accident Investigation 3 X Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 100 S. Frederick St. 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be determined 24 hours a (Specify) garage Baltimore. Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the ! 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifie 29c. License numbe 29d Date signed (Month, Day, Year) O.C.M.E December 11, 2006 30. Name and address of person who completed cause of death (Item 23a)

State

Registrar

Tasha Greenberg MD.

Year)

2006

31. Date filed (Mark)

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

egistrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Year Francine Pompay Easter 12 10 2006 1:53p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Nursing Home Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral <sup>Year)</sup> 50 1 □ M 2 🕅 F 219-56-3563 Director lď MD 56 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 U.S.A. 5900 Glenkirk Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes **¾**☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 2 X No 2 Specify Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Family Children Elementary/Secondary (0-12) College (1-4or 5+) Child Care Provider Support Services 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse James Moore Florence V. Butler ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1743 Champlain Drive Apt B, Balto, Md 21207 Aaron Easter-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory Inc 12/18/06 Metro Baltimore, Md 21. Signature/of Funeral Service Licenses 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Martins /Medical Due to (or as a nsequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ☐Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 2000 certificate 1□ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) NOS OUL Hospital: P 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

6908

32. Registrar's Signature

30. Name and/address of person who completed cause of death (Item 23a) (Type, Print)

2006

			1 For State	State of Maryland / De	epartment of Health and Certificate of Death	Mental Hygie	ne2006 39983
			Registrar  1. Decedent's Name (First, Middle, Last		Pertinicate of Death	Reg. 2. Date of Death	No.  3. Time of Death
	Physici		Dewayne	Everett		Decemb	Day Year
	/Medic Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of De		4c. County of Death
			NORTHWEST HOSP	ITAL	RANDAUSTOKIN		BALTIMORE
	Funeral		5. Social Security Number 6. Sec		Months Days Hours Mi	s. 8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		25.60.6960 Usual Residence of Decedent	53 Yr	S.	11.13.195	53 mo
	yland 10w		10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	Mar.	ctor	MD BALTIMO	RE WINDS	DR MILL		1 ☐ Yes 2 2 No
	라 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	8 23a	ral	7404 FAIRBROOM		21244		USA
	Item Item	Funeral	11. Marital Status 1 ☐ Never Married 2 <b>1</b> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 2 No	<ol> <li>Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue</li> </ol>	(Specify Yes or No- arto Rican, etc.)	14. Race - American Indian, Black, White, etc.
920	urs af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: BLACK
21215-0036	be filed within 72 hours after death with the Maryland stal Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Medical Exartinal must be rediffed at	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a. D	ecedent's Usual Occupation	16t	. Kind of Business/Industry
21	thu a	nple	Elementary/Secondary (0-12)	College (4-4or 5+)	Give kind of work done during most of w fe. DO NOT use retired)		
2	filed w Hygier Ither th		12 TH GRADE	N/A MIA	INTENANCE		OME SALES, INC.
Maryland	ntal H	Be	17. Father's Name (First, Middle, Last) FRANK EVERET		18. Mother's N.	ame (First, Middle, Maid	den Sumame)
Ž	pernit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 Is marked of any injury or other traumatic ev once.	ို	19a. Informant's Name/Relationship (Ty	ne Print) 19h M	lailing Address (Street and Number or F		troe Town State 75 Code
<u>S</u>	and 2 sauth ar n 27 is		JANICE EVELET	(MIFE) 74	4 FAIRBROOK RI		2 MIU, MD 21244
Ē,	f Heal		20a. Method of Disposition	20b. Place of D	isposition (Name of crematory or other place)		. Location - City or Town, State
E E	Pages nent of int: If it iry or o		1  Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		18.06 BA	auto. mo
Baltimore,	permit. Dep. rtn Importe any inju		21. Sign sure of Funeral Service License	99	22. Name and Address of Facility	e Division	SERVICE.
_	82589		vaushn C		22. Name and Address of Facility VAUGHN C. GREEN 5151 BALTO. NATC	PIKE BAUT	). MD 21229
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death. Do not se cause on each line.	enter the mode of dying, such as cardi	ac or respiratory arrest.	Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	atheroso	lerotic Hear	+ Diseas	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of)	11101		11
	LAdiminei	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of)	> Melitus		Tears
	uted	E I	cause. Enter Underlying Cause (Disease or injury that initiated events				
o	exec en an rial-tra	Examiner	resulting in death) Last	Due to (or as a consequence of):			
8760,	icate be executed physicien and the burial-transit	dicai					
	ing ph e as t	Med	IF FEMALE:				
Вох	death certiff e attending od for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?		3 □Ectopic pregnancy		23d. Date of delivery
	0 0 0	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)		Month Day Year
Δ.	res that the igned by be detected	F.	Part II. Other significant conditions con	tributing to death but not resulting in th	e underlying cause given in Part I	23e. Did tobaco	o use contribute to the cause of death?
g					, ,	1 ☐ Yes	
<u>5</u>	w requires been signatured to should the	Completed				24a. Was an	24h Wara sutangu findinga qualable
æ	The lav	E O				autopsy performed	
<u>ta</u>	ician: Th certificate rector, pag	a)	25. Was case referred to medical		26 Place of De	1 ☐ Yes 2 ☐1 path (Check only one)	No 1 ☐ Yes 2 ☐ No
<u>&gt;</u>	hysician: his certifical director,	ToB	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 ER/Outpa	Other	Home 5 Residence	6 ☐Other (Specify)
ב ב	ding Phy h. After thi funeral (		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28b. Tim (Month, Day Year) 1njury	e of 28c. Injury at	28d. Describe how in	
Sio	Attendi er death. rector: A by the fu	cati	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No		
Division of Vital Records,	or Atten efter deat Director: in by the	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Str	and Number or Rural Route Number, ate)
_	Hospitel or     24 hours effe     Funeral Dir letely filled in		29a. Certifier 10 Certifying Phys	icias: To the hest of my knowledge, d	eath occurred at the time, date and place	a and due to the	4)
	• Ho 1 24 h • Fur ietely	Medical	(Check only 2 Medical Examinone)	er: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death occ	urred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To the Hospitel or Attending Physician: within 42 hours deler death. To the Funeral Director: After this certifics completely filled in by the funeral director; completely filled in by the funeral director; p.	Me	29b. Signature and title of certifier		29c. License number	29d. [	Date signed (Month, Day, Year)
			KMaron	MD	D56418	Do	cember 9.200L
	2		30. Name and address of person who con	npleted cause of death (Item 23a) (Ty	DB, Print)	1	
			K. Tonya Mason	MD 5401 010	d Court Road, Ro	undallston	cember 9,2006 NN, MD21133.
	Sta Registra		31. Date filed (Month, Day, Year) DEC 1 5 20	32. Registrar's Signature	South 2		

State of Maryland / Department of Health and Mental Hygien 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 2 Pay **Physician** Dec 2006 6:50p M Kenneth A. Ellis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8501 Ramort Drive Nottingham Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 11XM 2□ F 220-34-5800 67 Director Yrs Nov.15,1939 Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Menial Hygiene. Important: If item 27 le marked other then "natural", or Items 23e or 28e-1 ehow any Injury or other traumatic event, the Medical Examinal character and be notified. 10d, Inside City Limits Director MD Baltimore Nottingham 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8501 USA Ramort Drive 21236 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Signature Flight Elementary/Secondary (0-12) College (1-4or 5+) Support 10th Machanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clifford Ellis Anita Sours ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Ellis /wife 8501 Ramort Drive Baltimore MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Bayview Crematory 12/14/06 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. Md Connelly Funeral HOme of Essex 21221 23a. Part1. Enter the disease, or conshock, or heart failure. List only flications that caused the treath. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) mml Canew /Medical Due to (or as a consequence of): Examiner Sequentially list conclines if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed nding physician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending physic IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) this certificate has been signed by the and director, page 2 should be detached in 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Yes 3 Probably 4 Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 🗆 Yes 2 Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA : After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred To the Hospital or many within 24 hours after death.

To the Funeral Director; After the funeral on by the fun 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 127730 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARR 6569 CHARLES ST Loud 10. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Thomas Edmunds Day Year th 2006 DECEMBER 4 2115 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) 5 -18-26 Birthplace (State or Foreign Country) **Funeral ™** M 2□ F Director 227-34-6279 80 Vrs Va. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location or Items 23a or 28a-f ehow 10d, Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1716 E. Belvedere Avenue 21239 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: Specify: Completed by Black 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) Longshoreman College (1-4or 5+) Local 333 Steamship Trade-9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Edmunds Mattie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and important: if item 27 is m any injury or other traum once. Pamela Samson Niece 1426 Innis Fallen Ave., Springfield, Oh. 45506 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Druidridge Cem. 12-14-06 Baltimore, Md. 21. Signature of Feneral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): Examiner ISCHEMIC BOWEL Sequentially list conditions, Tany, Lauring to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of): The law requires that the death certificate be executed CONGESTIVE HEART FAILURE Due to (or as a consequence of): Completed by Physician/Medical ISCHEMIC CARDIOMY OPATHY 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES MELLITUS 4 ViUnknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably HYPERCHOLESTEROLBMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed2 1 Yes 2 No PERIPHERAL VASCULAR DISEASE o the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 V Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٩ 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of perfiller 29c. License number 29d. Date signed (Month, Day, Year) Sprinkl P19470 12/4/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 601 600 HRAVEN PLVT SOMNATH GHOSH M.D BALTIMORE, MOZ 32 Registrar's Signature 31. Date filed (Month, Day, Year) DEC 1 5 2006 Registrar

1. Decedent's Name (First, Middle, Last)

Richard Fitzgerald

Physician

/Medical

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5029 Wilkens Avenue Catonsville Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F 219-32-2808 Director 76 07/09/1930 New Jersey Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or i any injury or other traumatic event, the Medical Examiner must be not injury or other traumatic event, the Medical Examiner must be not 5029 Wilkens Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsworth Fitzgerald ပ Matilda Fleishauer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5029 Wilkens Avenue, Catonsville, Maryland 21228 of Disposition (Name of Date 20c. Location - City or Town, State Dolores G. Fitzgerald (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 12/16/2006 Baltimore, Maryland New Cathedral 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. lances Immediate Cause (Final tast Me Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examiner burial-tran attending physician and for use as the burial-trai Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the aid be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MORU 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy perform 2 No spital or Attending Physician: Thours after death.

Ineral Director: After this certificate yfilled in by the funeral director, pa 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral DI 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 252746 Dec., 15,2006  $'^{\chi_y}$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yelen a Linnik, 720 Marter Choice with Polynocial MDU228 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

12/12/2006

4c. County of Death

10:45 A M

			For State Registrar	State o	f Marylan		artment rtificate				lental Hyg	iene <sub>eg. No.</sub>	06	399	87
	Dharaini		1. Decedent's Name (First, Middle, L								2. Date of Deal	th Day	Year	3. Time of	Death
	Physici /Medic		Violet	Forne	4		,				15	13	2006	8:30	AM
	Examir		4a. Facility Name (If not institution, g	ive street and nur	nber)		4b. City, 7	Fown, or	Location of	of Death		4c. Co	unty of Death		
			Genesis Perring					rkvi		Od Uso			ltimor		
	Funeral		,	Sex 1 □ M 2 X F	7. Age ( <i>In yr</i> s. 91	last birthday): Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day, March3,	1015	Coul	place (State ontry)	or Foreign
	Director		226-07-6347 Usual Residence of Decedent								Marcho,	1913	Va.		
Pue	A II		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside C	ity Limits
Man	E P	tor	Md. Balti	more	Г	Dundalk								1 🗌 Yes	2 XNo
d d	or 28	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen	of What Cour	ntry?	
1	23a c	alD	3130 Dunglow Rd					21	222			USA			
200	ems ems	Funeral	11. Marital Status	Armed Fo	dent Ever in U. rces?	.S. 13.	Was Deced	ent of Hi	spanic Ori	igin? (Spe	cify Yes or No- Rican, etc.)		Race - Americ Black, White,		
00	or lt	by Fu	1 Never Married 2 Married	If Yes, Giv	' <del>0</del>		1□ Yes 2		Specify:					ite	
Z   5-UUSO	price within 12 four sites death with the maryan other than "natural", or Items 23a or 28a-f show rent, tre Modical Examiner must be nutified at		3 XWidowed 4 □ Divorced  15. Decedent's	Year or D	ates:	16a Dece	dent's Usua	I Occupa	ation		ī	16h Kind	of Business/In	Z1 65	
3 2	n u	Completed	(Specify only highest g	rade completed)		(Give	kind of wor DO NOT us	k done d	lurina mos	it of worki	ng	TOD, KAIG (	n business/in	oustry	
	than	mo	Elementary/Secondary (0-12) 12 yrs.	College (1	-4or 5+) 2 yrs		ecret	arv				Shi	.pyard		
ם פֿ	at, and	a)	17. Father's Name (First, Middle, La.	st)							(First, Middle, I	Maiden Sui	name)	-	
yland yland		S B	Ernest Bell						Ac	die B	eli				
Mar)	and Mental		19a. Informant's Name/Relationship	(Type, Print)			_				I Route Number			Code)	
Z .			John Forney	son					Rd.		alk Md.				
	ges I and a should to Health and Mer If item 27 Is marke or other treumatic		20a. Method of Disposition 1 □ Burial 2 🏋 Cremation 3	☐Removal from	State	Place of Dispo cemetery, crer	natory or ot	her place		ec. 1	ate 13.		on - City or To		
	tment tent: jury		* 4 ☐ Donation 5 ☐ Other (Spec	cify)	Ba	lyview				20	006		timore		
baltimore,	Department of Healt Importent: If item 2 any injury or other once.		21. Signature of Furniral Service Lic	ZZ h							me of Dukd. 2122				
			23a. P. 11. Enter the disease, or co	mplicatio o that c	aused the deat									Approximat Interval Bet	e ween
P	hysician		Immediate Cause (Final disease or condition	10			i	une	7 Co	unc	_			Onset and I	Death
	/Medical		resulting in death)	Due to	or as a conseq	uence of):									
	xaminer		Sequentially list conditions,	b											
72 3	a ts	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a conseq	uence of):									
- 100	and I-tran	хап	that initiated events resulting in death) Last	c	or as a conseq	uence of):							70		
3 / DU,	ician														
199	phys s the	edical		d											
Box 68/60, x	been signed by the attending physician and should be detached for use as the burial-transit	hysician/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregna							23d.	Date of delive	ery	
ă	a atte	Cial	in the past 12 months?	4 Pregn	irth 2 ☐ Feta ant at time of d		]Ectopic pre ] Other (spe						Month	•	Year
j }	by the	hys	9 Unknown	9□ Unkn	own										
ords, P.O	ned bed	by P	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the u	nderlying ca	use give	in in Part I		23e. Did tot	oacco use	contribute to the	ne cause of c	leath?
cord	en sig										1 □ Ye	s 2□N	o 3 rot	ably 4 🗆	Jnknown
S S	u co	ompleted									24a. Was a autops	n 2	b. Were auto	psy findings mpletion of c	available
1 2	ate h page	Com									perform	ned?	death?		
VICE The	is certificate director, pag	Be (	25. Was case referred to medical examiner?								(Check only on				
Or VITA	this or	2	1 ☐ Yes 2 ☐ NO		npatient 2 🗆						me 5□Reside			v)	
	After t funera	on:	27. Manner of Death  1 ☐Natural 5 ☐ Pending		of Injury th, Day Year)	28b. Time of Injury		3c. Injury Work	:?		28d. Describe ho	ow injury oc	curred		
Sic	tor: /	catl	2 Accident investigat 3 Suicide 6 Could not	he	of fairner As for		М		/es 2 □		206 Leastine /Cr			I Courte Man	
UNISION	Direc Direc in by	ertification;	4 Homicide determine	286. Place	of Injury - At hong, etc. (Specify	y)	eet, factory,	OTTICE		4	28f. Location (St City or Town		imber or Hura	ii Houte Num	iber,
- lotic	erel l	O	29a. Certifier 1 Certifying I	Physicien: To the	hest of my kno	wledge death	n occurred a	at the tim	e date an	nd place a	and due to the co	ause(s) and	manner as s	tated	
3	within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical		aminer: On the ba											)
, d	within To the	Me	29b. Signature and title of certifier						number			9d. Date si	gned (Month,	Day, Year)	
-	, - 0		> Staling	MD			1	> 0	064	104		Dee.	3 06		
	ہے		30. Name and address of person wh	o completed caus	e of death (Item	n 23a) (Type,	Print)					-			
	5		SIMIN BUILD	7	GBMC	Suite	4202	6	701	N.Che	erries 5T	lans	m, MD	21204	
	Sta		31. Date filed (Morth Day, Year)	2006 32.F	egistrar's Signa	turo de	346								
	Regist	rar	APA TO	2000	State of the state	1									

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

N. Charles

6701 32. Registrar's Signature

A SECTION

St. Balto Md 20204

			1 - For State Registrar		epartment of Health ar Certificate of Death	nd Mental Hygien	2000 07707
13 %	Physic	ian	1. Decedent's Name (First, Middle, Last)	\$		2. Date of Death Month Da	3. Time of Death
5	/Medi	cal	Cillian Groom			December	9 2006 1:03 FM
	Exami	ner	4a Facility Name (If not institution, give s  5. Social Security Number 6. Sex	Hospital	4b. City. Town, or Location of BACTIMORE  day) If Under 1 Year   If Under 24		: County of Death
	Funeral Director			W AND COL		Hrs. 8. Date of Birth (Month, Day, Year, OC+ 8) 19	9. Birthplace (State or Foreign Country)  NC
	yland		10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	Mar-1 st	tor	Md N/A	Balti	more		1 Ves 2□No
	or 28	Director	10e. Street and Number		10f. Zip Code	10g. Ci	tizen of What Country?
	23a		1104 Elbank A)	re	21239	U:	SA
215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Iteme 23e or 28e-1 show avent, the Medical Examiner must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Pyes, 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
9	72 ho	ted	15. Decedent's Educ		Decedent's Usual Occupation	16b. k	Cind of Business/Industry
2121	l within 7 iene. r then "r ine Med	Completed	(Specify only highest grade	Coltege (1-4or 5+)	Give kind of work done during most of ite. DO NOT use retired)	t working	Dwn Home
	illed Hygi other	Be C	17. Father's Name (First, Middle, Last)			Name (First, Middle, Maider	
Maryland		To B	John Hardy		Man	vie Gibbs	
ary	and and series		19a. Informant's Name/Relations ip (Ty)	pe, Print) 19b. N	Mailing Address (Street and Number of		or Town, State, Zip Code)
_	1 and 2 Health em 27 thar tra		Diane Verma	Daughter III	4 Elbank Ave Bo	altimore Ma	21239
ore	S 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	nom otom.	Disposition (Name of crematory or other place)	Date 20c. L	ocation - City or Town, State
Ë	Pages Iment of tant: If It jury or o		4 □ Donation 5 □ Other (Specify)	Entombreat Woodla	wn Cemetery 12	1/16/06 Wo	odlaun Md.
Baltimore	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	la.	22. Name and Address of Facility		vers tuneral Home
	205 # Q		Jerry Hu	sr.	5240 Reisterstou	UN Ad Baltin	10/2 Md 21215
	Pnysician		23a. Pany. Enter the disease, or complished, or heart failure. List only on the disease or condition resulting in death)	cations that caused the death. Do no e cause on each Me.	t enter the mode of dying, such as call.  Muccan chal	In factory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of)		/	
		niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	Due to (or as a consequence of)	:		
60,	ficate be executed physician and s the burial-transit	al Examiner	that initiated events cresulting in death) Last	Due to (or as a consequence of)			
68760,	phys the	edical	d d				
. Box	death certi e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	ac. If yes, outcome of pregnancy 1 □Live birth 2 □Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
	res that the de igned by the a be detached t		Part II. Other significant conditions con	tributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacco i	use contribute to the cause of death?
Vital Records,	w requires that the been signed by th should be detache	ed by					□ No 3 □ Probably 4 Unknown
ec c	law as b 2 si	Completed				24a. Was an	24b. Were autopsy findings available
Œ.	0 4 0	mo.				autopsy performed? 1 ☐ Yes 2 2 No	prior to completion of cause of death? 1 ☐ Yes 2 ♣ 400
/ita	Attending Physician: Th r death. ector: After this certificate by the funeral director, pag	Be (	25. Was case referred to medical examiner?	2010	26. Place of	Death Check only one	
-to	Physia this caral dire	ပ္	1 ☐ Yes 2. No	ospital: 1 ☐ Inpatient 2 📜 R/Outpa		ng Home 5 Residence	6 □Other (Specify)
LO .	ding P h. After t funera	i.	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tim	ry Work?	28d. Describe how injur	y occurred
Sic	ottend death ctor: / the fi	cati	2 Accident investigation 3 Suicide 6 Could not be		M 1 Tes 2 No		
É	tal or Al	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Roule Number, )
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)	ician: To the best of my knowledge, o er: On the basis of examination and/o and manner stated.	leath occurred at the time, date and por investigation, in my opinion, death o	lace, and due to the cause(s) occurred at the time, date and	and manner as stated. place, and due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier		29c. License number	_29d. Dat	e signed (Month, Day, Year)
) '			Alun 120 A	len	D3554:	3 Don	puper 12, 2m1
	1.		30. Name and address of person who	plited cause of death (Item 23a) (Ty	rpe, Print)	,,00	ember 12, 2006 re, Maryland
111	$\varphi$		KEVIN H. Scruggi	Ms Steel Lock	Raven Boulevan	Q Baltima	re Maryland
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 5 2006	2. Registrar's Signature	will	\$= :	1

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Vear **Physician** 2000 PM Stella H. Goins 2006 DECOMBER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Memorial Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12/17/1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 T F 80 MD 219-16-6221 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director MD Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 119 Sandy Beach Drive 21122 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White <u>ک</u> 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Andreone Rose Papa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6 Olivia Wist / Daughter Cedar Circle, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Entombment 1 ☐ Burial 2 ☐ Cremation 4 □ Donation 5 X Other (Specify) Glen Haven Mem Pk 12/14/06 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityG. J. Gonce Funeral Home, PA 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 2 DAYS disease or condition resulting in death) BRAIN STEM INFALLT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ATRIAL FIBRILLATION 2 DAYS Due to (or as a consequence of) Examiner for use as the burial-tran and Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the huria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ို funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Egallognei AT2432946 DECEMBER 10 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATHELINE GALLAGHER UNION MEMORIAL HOSPITAL, MO aw 31. Date filed (Month, Day, Year) 32 Begistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Division or Vital Records. P.O. Box 68760.

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment ertificate	of H	ealth a Death	and N		iene	06	39991	Annual Control
	Physici	an	Decedent's Name (First, Middle, Last	t)						2. Date of Deat Month	h Day	Year	3. Time of Death	
	/Media	cal	Rose Lee			T				Dec.	10 2	2006	4:15AM	1
	Examir	ner	4a. Facility Name (If not institution, give	· ·		4b. City, T	own, or: sex		of Death		4c. County	of Death		
	Funeral		5. Social Security Number 6. S		(In yrs. last birthday	If Under 1	Year	If Under	24 Hrs.	8. Date of Birth			lace (State or Foreigntry)	 n
	Director		213-66-7389	□M 2 <b>⊠</b> F	52 Yrs.	Months	Days	Hours	Min.	May 6	1954	Mar	yland	
	pue *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or L	ocation							0d. Inside City Limits	_
	Maryli f sho	jo	MD Baltim		•	Essex						'	1 Yes 2 No	
	r 28a	Director	10e. Street and Number			10f. Zip C	Code			1	0g. Citizen of	What Cour	itry?	_
	within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28e-f show ta Mexical Evarid at must be notified at	alD	411 Delaware	Avenue			212	21			USA			
	r dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decede	nt of His	panic Orig	gin? (Sp	ecify Yes or No- Rican, etc.)		ce - Americ		
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ♣ ♠ Divorced	1 ☐ Yes 2 ☐ <b>X</b> No If Yes, Give Year or Dates:		1 ☐ Yes 2				,,	Specify: White			
8	2 hour		15. Decedent's Ed		16a. Dece	dent's Usual	Occupat	tion			16b. Kind of B			_
215	hin 73	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of work DO NOT use	done du retired)	uring most	of work	ing	,			
2	filed wil Hygien other th	Con	12th			ger H	elp	er			Coas	t Gu	ard	
and	be fill d off	Be	17. Father's Name (First, Middle, Last)  Seebert L. Ha	rtlow C						e (First, Middle, M		ne)		
<u> </u>	should be ind Mental marked o umatic eve	ဥ	19a. Informant's Name/Relationship (7				Chanada			es Dud]				
Σ	and 2 s eelth an m 27 ie i		Carles Hartley							ue Balt				
Baltimore, Maryland 21215-0036	- f = 5		20a. Method of Disposition		20b. Place of Disponentery, cre	osition (Name	of	Ţ			20c. Location -			_
Ē	Pages nent of I ant: If its		1  Burial 2  □ Cremation 3  □ 4  □ Donation / 5  □ Other (Specify		Holly H	Hill C	ceme	etery	y 12	2/14/06	Balt	imor	a MD	
ä	permit. Departrimportri	4 Donation / 5 Other (Specify)  Holly Hill Cemetery 12/14/06  22. Name and Address of Facility  300 Mace												
	40 E 8 a		" Collection	Home	of Es	sex :	21221							
			23a. Part . Enter the disease, or comp shock, or heart failure. List only	est,		Approximate Interval Between Onset and Death								
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Melas		alyn	X	Car	1 cer			0	ne year	
	Examiner			Due to (or as a	consequence of):	8							0	
		Jer	Sa uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):									_
K	acuted ind transi	Examin	that initiated events	c										
8760,	ate be executed hysicien and the burial-transit	E	resulting in death) Last	Due to (or as a	consequence of):									
687	ate the	dical		d			_							
Box	law requires that the death certific as been signed by the attending p. 2 should be detached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							23d Dat	te of delive	rv.	_
ň	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at tir		∃Ect <i>o</i> pic preg ∃ Other (s <i>pec</i>					Mo		Day Year	
o.	at the	hys	9 Unknown	9L] Unknown										_
Ś.	res that the de signed by the a be detached f	۵	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cau	se given	n in Part I.		\ \			e cause of death?	
Ö	w require been signal	eted								110	s 2 □ No	3 Proba	ıbly 4 ∏Unknown	
ě	9 - 9	Completed								24a. Was an autopsy perform	r	orior to corr	sy findings available pletion of cause of	,
	ician: Th certificate rector, pag	င္ပ	25. Was case referred to medical							1 ☐ Yes 2	No 1	death?	2 🗆 No	
>	9 (0 = 1	0 B	examiner?	Hospital:	2 ER/Outpatier	at 3□ D∩A	Other			Check only one	nce 6 ∐Othe	/04		-
	ding Ph h. After th funeral	Ü.	27. Manner of Death	28a. Date of Injury (Month, Day Y			. Injury a Work?			28d. Describe hov				_
S S	Attending r death. ector: After by the fune	catic	2 Accident investigation		, ,,,,,,	М		es 2□N	lo					
DIVISION	or Att	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	- At home, farm, str (Specify)	eet, factory, o	office		4	28f. Location (Stre City or Town,	eet and Numbi State)	er or Rural	Route Number,	_
	pital ours a lerai [	ဦ	29a. Certifier 17 Certifying Phy	gicing: To the best of	mu knawladaa daati		M	4-1						
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	edical	(Check only 2 Medical Exam	sician: To the best of r ner: On the basis of ex and manner state	kamination and/or in	vestigation, in	my opir	, date and nion, death	piace, a	and due to the car ed at the time, da	use(s) and ma te and place, a	nner as sta and due to	ited. the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier			29c. L	icense r	number		29	d. Date signed	(Month, D	Pay, Year)	_
}			1 13n	ni		D	54	186	11		12/1	2/0	6	
	6		30. Name and person who c	ompleted cause of dear	th (Item 23a) (Type, RCL 5 U.1. s Signature	Print)	~	1			- /			
			31. Date filed (Month, Day, Year)	adelphia	Rd Suis	te 201	8	BA	41 tc	s. Md.	21237	ree)		
9.	Sta Registra		DEC 1 5 20	06 Personal	July 1018	age of								

DHMH 17 Rev 1/2001

39992

		For State of Maryland / State of Maryland / Registrar		nt of Health and atte of Death	Mental Hy	ygiene ( Reg. No.		0 0 0 0 0 6
1949 mg		Decedent's Name (First, Middle, Last)			2. Date of D	eath Day	Year	3. Time of Death
Physici /Medic		Helen Elizabeth Goulden			12	10		12:55 PMM
Examin		4a. Facility Name (If not institution, give street and number)	4b. Cit	y, Town, or Location of Deat	h	4c. C	ounty of Death	
		Upper Chesapeake Medical Center	B€	el Air, Maryl	and	Н	arford	
Funeral		<ol> <li>Social Security Number</li> <li>Sex</li> <li>Age (In yrs. last to the security Number)</li> </ol>	Months	ler 1 Year If Under 24 Hrs s Days Hours Min.	(Month, E	irth Day, Year)	9. Birthp Cour	place (State or Foreign ntry)
Director		217-28-6605 1□M 2XF 74	Yrs.		08/08	3/1932	Wes	t Virginia
D .		Usual Residence of Decedent           10a, State         10b, County         10c, City, To	own or Location				1	10d. Inside City Limits
aryla	2							1 □ Yes 2X No
ne M	octo		ostead	T- 0-1-		10a Citiza	en of What Cour	-t/2
vith to	급	10e. Street and Number		Zip Code				itry :
21215-0036 4 within 72 hours after death with the Maryland liene. Then "natural", or iteme 23e or 28e-1 show the Maidical Examinational be notified at the Maidical Examination of the Maidical and the Maidical Examination	by Funeral Director	1724 Indian Court  11 Marrial Status 12. Was Decedent Ever in U.S.		21074	Specify Vec or N		. Race - Americ	can Indian
(J- # ##	n n	Armed Forces?	If Yes, sp	cedent of Hispanic Origin? (S becify Cuban, Mexican, Puer	to Rican, etc.)	0.	Black, White,	
36 36 17,01	, F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 🗆 Yes	2  ☑ No Specify:		S	pecify: Whi	+0
215-0036 (Ithin 72 hours after in Tabural; or in Medical Example)	be		Sa. Decedent's Us	sual Occupation		16b, Kind	of Business/In	
15 in 72 in 72	Completed	(Specify only highest grade completed)	(Give kind of w life. DO NOT	work done during most of wo	rking	Balti	more Co	ounty
212 ad with er ther	E	Elementary/Secondary (0-12) Coltege (1-4or 5+)	Cafeter	ia Worker		Board	of Edu	cation
44 200		17. Father's Name (First, Middle, Last)	Carecers	18. Mother's Na	me (First, Middi			CACIOII
- 0 m p	To Be	Gladstone Abell		Hazel	Kaylor			
Maryland Maryland 12 should be file h and Mental Hy 71s marked oth	-		9b. Mailing Addre	ess (Street and Number or R		ber, City or 1	Town, State, Zip	Code)
ore, Maryla ges 1 and 2 should t of Health and Men If item 27 is marke or other traumatic		Christine M. McCann (daughter)	1724 Tre	dian Court -	Hamoste	ad. Ma	rvland	21074
re, M		20a Method of Disposition 20b. Place	of Disposition (N	lame of	Date		ation - City or To	
Baltimor Demit. Pages Department of Moorann: If its any injury or o		1 \(\triangle \text{Burial}  2 \( \triangle \text{Cremation}  3 \( \triangle \text{Hemoval from State} \)	tery, crematory or		E /2006	Till	loatorm	DΛ
Ltin		21. Signature of Funeral Service Licensee		Cemetery 12/1 and Address of Facility E				
Baltimor permit. Pages Department of i				Belair Road				
		23a Part 1 Enter the disease or complications that caused the death. D					ricit y 10	Approximate
		23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.						Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	wander	accelent				
/Medical Examiner		Due to (or as a consequence	e of):	1				
0	-	Sequentially list conditions,  Due to lor as a consultance.	o ofly					
4	ine	if any faeding to in mediate cause. Enter Underlying Cause, (Disease or injury	- OI					
and and	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence	te of):					
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~ <b>∞</b> ₩ ₹ €	edicai	d					_	
X 6 entific		IF FEMALE: 23c. If yes, outcome of pregnancy						
M 80 (	an/	230. Was decedent pregnant 1 Live birth 2 Fetal dea	ath 3□Ectopic			23	<li>Id. Date of delive Month</li>	ery Day Year
O. I be de	sic	1 Yes 2 No 9 Unknown	5 ☐ Other (	(ѕреспу)		-		
IS, P.O. BOX igned by the attending be detached for use	by Physician/M	Part II. Other significant conditions contributing to death but not resulting	a in the underlying	n cause given in Part I	23e. Dic	I tobacco use	a contribute to t	he cause of death?
ords,		Tak ii. Other digital continues of the day of the continues of the continu	y in the directly ing	y sauss grown in rain.		]Yes 2□		bably 4 Unknown
Cords, requires the	Completed				-			
Rec elaw has b	ğ				24a. We	opsy	24b. Were auto prior to co	opsy findings available impletion of cause of
The The page	ő					formed?	death? 1 ☐ Yes	2 No
of Vital Re Physician: The la	Be	25. Was case referred to medical examiner?			ath (Check only	one)		
of V of Physic rthis or	P	1 ☐ Yes 2 ☐ No Hospital 1 Inpatient 2 ☐ ER/	Outpatient 3 1		Home 5 ☐ Re	sidence 6	Other (Specif	(y)
On O		27. Manner of Death  Natural 5 ☐ Pending  28a. Date of Injury (Month, Day Year)  28b. Martin (Month, Day Year)	b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury	occurred	
elen	Certification:	2 Accident investigation	M	1 Yes 2 No				
Division or Attenuted deat	₩	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, facto	tory, office	28f. Location City or T	(Street and own, State)	Number or Rura	al Route Number,
Di Bpital o								
tospi thou uner uner	cai	29a. Certifier (Check only)  Certifying Physician: To the best of my knowled  (Check only)  Medical Examiner: On the basis of examination						
To the Hos within 24 h To the Fun completely	ed	one) and manner stated.				·		
Division o  To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	Σ	29b. Signature and title of certifier	2	29c. License number		_	signed (Month,	
, ·		Day 5 Den		035522		Deci	custon	11,2007
4		30. Name and address of person who completed cause of death (Item 23)		_ 1	3 -			
0		31. Date filed (Month Day, Year) DEC 1 5 2006  32. Registrar's Signature	MARPH	A.SI 02=/4	1- 136	۷		
	ate	31. Date filed (Mooth Day, Year)  DEC 1 5 2006  32.Registrar's Signature	Social	,				
Regist	ar	TO LOVE ANTICON JOS	The same					

			1 - State Amend #28f, peri	State of Maryla ME, g862, 12/21/	ind / Depa 06 TT <i>Ce</i>	artment of <i>rtificate o</i>	Health and of Death	Mental Hyg	giene 0 0 6	39993
	- 64	7	Decedent's Name (First, Middle, Las	()				2. Date of Dea	ath	3. Time of Death
	Physicia /Medic	Sec. 1	Betty (	Stahan				Month 1 2	Day Year	7:26 AM
	Examin	D 4	4a. Facility Name (If not institution, give	street and number)	1.	4b. City, Town	, or Location of Deal	h	4c. County of Dea	th
**			Good Jamer			1331	1 more			
	Funeral	5916	5. Social Security Number 6. Se	□M 2MF	rs. last birthday) Yrs.	If Under 1 Ye Months Day		(Month, Da)	y, Year) Co	thplace (State or Foreign ountry)
	Director	}	219-52-5092 Usual Residence of Decedent	56	)			2–18-	-50	S.C.
	land ow		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Mary -f ah	tor	Md. NA		Balt	imore				1 X Yes 2 ☐ No
	r 28e	Director	10e. Street and Number			10f. Zip Cod	е		10g. Citizen of What Co	ountry?
	72 hours after death with the Maryland natural; or iteme 23e or 28e-f ahow Jisal Examina rount be notified at	a D	5633 Purdue Avent	ue		212	39		USA	
	deat	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of	of Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	- 14. Race - Ame Black, Whi	
9	or It		1 Never Married 2 Married	1 ☐ Yes 2 🔀 No If Yes, Give		1 ☐ Yes 2 <b>∑</b> 1	No Specify:		Specify: B	lack
21215-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates:	160 Door	dent's Usual Oc	equation		16b. Kind of Business	/Industry
<del>1</del> 5	"nat	Completed	15. Decedent's Ed (Specify only highest gra-	de completed)	(Give	kind of work do DO NOT use re	ine during most of wo tired) Jus	rking Stice	TOD, KING OF BUSINESS	Viridustry
12	within lene. than "	шc	Elementary/Secondary (0-12)	College (1-4or 5+)			Dept. of		State of	Md.
	e filed within al Hygiene. I other than "	a l	17. Father's Name (First, Middle, Last)		1				Maiden Surname)	
<u>a</u>	lid be Sental rked c	To B	Willie	C.	Vic	od	Chris	stine	Brow	n
Maryland	2 should be and Mental is marked of raumatic ever		19a. Informant's Name/Relationship (7	Type, Print)		•			er, City or Town, State,	
	is 1 and 2 of Health a Item 27 is		James E. Graham	Husband	563	33 Purdu	e Avenue,			239
Baltimore,			20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐		<ol> <li>Place of Disposers, createry, createry</li> </ol>	osition (Name oi matory or other	place)	Date	20c. Location - City or	r Town, State
Ĕ	Pages nent of ent: If It ury or o		4 Donation 5 Other (Specif)	() C	Garrisor	n Forest	Vet 12-	The second secon	Owings Mi	lls, Md.
alt	permit, Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licen	1500	2		Idress of Facility	March F.	.H. East altimore, M	d. 21202
_	205 = 9		1 Dlady	p wans						
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the di one cause on each line.	eath. Do not en	iter the mode of	dying, such as cardia	c or respiratory ai	rest,	Approximate Interval Between Onset and Death
E Sor .	Physician		Immediate Cause (Final disease or condition resulting in death)	a Asys	Tole				A	75 min
	/Medical Examiner		resulting in death)	Due to (or as a cons	1			1	EJAHIN	
	· 多类。遵	er	Sequentially list conditions, if any, leading to infriedate cause. Enter Underlying	b. Dua to for an a cons	10/6 3	2	/	1 / 6	HCAL	
	ted	nlne	Cause (Disease or injury	Cille.	, f: o		6- 67	DENT		
	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a cons				APPROVED BY THE		
8760	sicier sicier b buri	cal		d			- Trans	TIP		
89	ificate g physi as the b	P		-			S. F. F.	1		
Вох	n certific anding p use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		□Ectopic pregna	ancy		23d. Date of de	,
	death o	100	in the past 12 months? 1 🗆 Yes 2 🗷 No	4 Pregnant at time of		Other (specify			Month	Day Year
P.0	by the	hys	9 🗆 Unknown							
	res that the de signed by the a be detached	by 6	Part II. Other significant conditions of	contributing to death but not	-	underlying cause	e given in Part I.		obacco use contribute t	Probably 4 Unknown
ord	equir Ben s Iould	ted	Kespirator	7 12.701	-		<del></del>	'		
ec	e law re has be	ap.	fever					24a. Was autoj	psy prior to	utopsy findings available completion of cause of
of Vital Records,		Completed						1 Tes	ormed? death?	s 2 No
/ita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital			Othor	eath (Check only o		
of	S 5	2	1 Ness 2 No		28b. Time				dence 6 Other (Spa	ecify)
- L	ding F	lon	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year			Injury at Work? 1 ☐ Yes 2 ☑ No	Fp /1		PSOFFICIE
<u> S</u>	or Attending after death. Director: After in by the fune	Ca	2 Suicide 6 Could not b	9 290 Place of Injury -	UNI At home, farm, s			28f. Location (	Street and Number of F wp, State) 2815 W.	
Division	after Dire	Certification:	4  Homicide determined	building, etc. (Sp	ecify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	1	Mulberry St.
_	spite nours nerel			nysician: To the best of my	knowledge, dea					
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral	edical	(Check only 2 Medical Examone)	miner: On the basis of exam and manner stated.	nination and/or i	nvestigation, in r	my opinion, death occ	curred at the time,	date and place, and du	e to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	1		29c. Li	cense number		29d. Date signed (Mor	nth, Day, Year)
	/		1 W/W/	_ M.	D.	100	060459		12-10-	06
	6		30. Name and address of person who	completed cause of death (	Item 23a) (Type	e, Print)	21.	7	1+0	70 21239
						4 Rau	en Blud	1791	I more,	10 21239
	St Regist	ate rar	31. Date filed (Month, Day, Year)  DEC 1 5 21	32 Registrar's S	ignature	BALL				

		For State	State of Ma		l / Depa		lealth and N	Mental Hyg	jiene	nn		99	91,
Physicia		Registrar     Decedent's Name (First, Middle, Las.	")			inicate of	Death	2. Date of Dea Month	Day	Υ.	3.	Time of D	Death
/Medica	/Medical Dorothy R. Gehrmann  4a. Facility Name (If not institution, give street and number)						Decem			, 200		607	M
Examine	r	Suburban Hospita				Bethe	r Location of Death			County of Monts	zomery	7	
Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day			mi di ili	(0)	Foreigr
Director		Usual Residence of Decedent	]M 2120 F	92	Yrs.	Months Days	Hours Min.	July 23	, 19	14	Country)		
anylan show d at	_	10a. State 10b. County 10c. City, Town or Location										nside City 1 □Yes 2	
he Ma	Director	Maryland Montgomery Rockville  10e. Street and Number 10f. Zip Code							O- Citi-	on of Miles	at Country?		- 140
with t			u-1 Am 0.36	tmont	- 201	20851					-		
ms 23	<u> </u>	13211 Twinbrook Par	12. Was Decedent E			. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				nited States  14. Race - American Indian,			
/2 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	2	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🕱 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	0		1 ☐ Yes 2 ☑ No Specify:			Black, White, etc.  Specify: White				
nin 72 ho e. an "natur Medical I	Completed	15. Decedent's Edi (Specify only highest grad	ucation le completed) College (1-4or 5+	+)	16a. Deced (Give life. I	dent's Usual Occup kind of work done DO NOT use retire	pation during most of worl d)	king	16b. Kin	nd of Busin	ness/Industr	у	
ygiene giene er the t, the	5	12			Regi	onal Man					Comp	any	
be tilk d oth d oth event	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam			Surname)			
Men Men Marke	요	John Henry Redm			401 11 11			B. Dishm					
d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (7)  Dorothy Marie K		tar		•	and Number or Ru keshore,			,	., .,	le)	
1 and Healt tem 2	-	20a. Method of Disposition	Tern/Daugn	20h Pla	ace of Disno	sition (Name of	1	Date			y or Town,	State	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Commation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service License)	MO1473	Cr	Mont emato Be Be	thesda-C	20( ess of Facility Ro Thevy Chas Maryland	06 bert A. se, Inc. 20814-3	Pump 75 501	hrev	Lscons	al Ho sin A	ome ve.
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  a. Cerebrovascular Accident  Due to (or as a consequence of):  b. Due to (or as a consequence of):									inte	proximate erval Betwe set and De	en eath	
sicia	Physician/Medical Examiner	resulting in death) Last	Due to (or as a d	of pregnan 2 ∐ Fetal (	cy death 3	]Ectopic pregnanc	у		2	3d. Date o	-	Ye	
by the attentached for u	hysic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4□Pregnant at t 9□Unknown			Other (specify) _							
requires that the een signed by the nould be detache	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Atrial Fibrillation						23e. Did tobacco use contribute to the cause of de 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Ur					
icate has been, page 2 sho	Completed					sy med? 2 2 No	prio dea	re autopsy f or to comple th? Yes 2	tion of cau	railab ise of			
sicial certificacto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2000	B/Outpation	t 3DDOA Oth	or.	th (Check only or		Пс::	(0 ":		
a Fny er this eral di	9	27. Manner of Death	28a. Date of Injury	y 1	28b. Time o	, 30 DOX	4 Li Nursing n	ome 5 Resid			opecity)		
To the Topping of Amending Prysical: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	27. Manner of Death 1							treet and n, State)	l Number (	or Rural Ro	ute Numbe	er,
e Hospi 24 hour e Funer letely fills	Medical		rsician: To the best of iner: On the basis of and manner state	examinati									
To the within To the complete	Me	29b. Signature and filerof certifier	^			29c. Licens	se number 2949	2	9d. Date	e signed (I	Yonth, Day,	Year)	
10		30. Name and address of person who was Natasha Haag, M.D.				-	Bethesda	, Maryla	nd 2	.0814			
Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	INO.	rever							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death **Physician** 4c. County of Death /Medical Facility Name (If not institution, give street and number Town, or Location of Death Examiner sheldon Jenue HMORE Year If Under 24 Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Min. Months Days 1 ☐ M 2 X F Hours Director OMM (arolina Pages 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hyglene. and it if them 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "and or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 □ No Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1X Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, 60) NOT use retired) College (1-4or 5+) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surnar Be ٩ 19b. Mailing Address (Street and Number or Rural Route Number, 20b Place of Disposit 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licensee Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) ARREST **Physician** NEDIU MCCMONNEY /Medical Due to (or as a consequence of) **Examiner** trasiv Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): or Vital Records, P.O. Box 68760, Physician/Medical the nding pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 12 No 9 Unknown 9 Unknown Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by icin 2 No 3 Probably 4 Unknown OB < 31 Mo-5. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 14 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2∏No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 6 Name and add 33rd Street #136 M200 32, Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#20b, 20c, per FH, G862, 12/15/06 WS
State of Maryland / Department of Health and Mental Hygienes

			1 - For State Registrar	State of	Maryland		artment of H		and M	éntal Hy	giene Reg. No.		39996	
	Physici /Medi		1. Decedent's Name <i>(First, Middle, L</i> VEI	ast) RA A HENR'	Y					2. Date of De Month DEC		, 006 Yea	3. Time of Death 9:30 AM	
	Examir		4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				4b. City, Town, or Location of Death BETHESDA					eath MERY		
	Funeral Director		051-16-2222	Sex 7. 1 □ M <b>2</b> 1 □ F	Age (In yrs. l	V	If Under 1 Year Months Days	If Under: Hours	Min.	8. Date of Bi (Month, Di June 14	ay, Year)	9. E	hirthplace (State or Foreign Country) EW York	
	ne Maryland Ba-f ehow	ector	Usual Residence of Decedent  10a. State 10b. County  Virginia Prince	William		, Town or Lo						10d, Inside City Limi 1 ☐ Yes 2 N		
	with the a or 2	Dire	10e. Street and Number 3200 Riverview	Design			10f. Zip Code				_	zen of What	Country?	
980	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Exp. infertinates notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	XN0		22172 Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☒ No	lispanic Origina, Mexican	gin? (Spe n, Puerto F	cify Yes or Na Rican, etc.)				
215-0036	nin 72 hou n "nature Nedical E	Completed by	15. Decedent's I (Specify only highest g	Education rade completed)	de completed) (Give k		dent's Usual Occupation kind of work done during most of working DO NOT use retired)			16b. Ki	ss/Industry			
2	12 should be filled within hard Mental Hygiene. 7 is marked other than "rearmatic event, the Mexical Comments."	Com	Elementary/Secondary (0-12)	4	Or 5+)	Proto	ocol Offi						. State	
Maryland	be fill hy od oth	Be	17. Father's Name (First, Middle, Las	it)						(First, Middle				
ryla	hould d Mer marke matic	유	Bohumir Demuth  19a. Informant's Name/Relationship	(Type Print)		19h Mailir	ng Address (Street		-	obtain		2012	Zin Code)	
Ma	and 2 s salth an n 27 is i		John O. Henry, J		and		Riverview							
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 t eny injury or other tre once.		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec	□Removal from Sta	20b. PI	ace of Dispo	osition (Name of matory or other place National (	(0.0	D	ate	20c. Lo	cation - City	or Town, State	
altii	permit. Page Department o Important: If eny injury or once.		21. Signatore of Fyneral Service Lice		vuan	22	ACTIONAL ( 2. Name and Addres	ss of Facilit	ery 1	ntcast	le Fu	ineral	virginia Home	
8	8258		Labort for	Collen		4	143 Dale	Blvd.	, Dai	le Cit	y, Vi			
	Physician /Medical Examiner	ilner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. RESF	PRITORY as a consequence of the death	FAILI		g, such as	cardiac of	respiratory a	arrest,		Approximate Interval Between Onset and Death	
68760,	ificate be executed g physician and as the burial-transit	edical Examiner	that inlusted events resulting in death) Last	c. Due to (or	as a consequ	ence of):								
O. Box	The law requires that the death certified has been signed by the attending tage? should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 XNo 9 □ Unknown		n 2 ∏ Fetal It at time of de	death 3	Ectopic pregnancy Other (specify)				2	23d. Date of o Month	lelivery Day Year	
ds, P.	luires that n signed b ild be deta	by	Part II. Other significant conditions	contributing to deal	th but not resu	ilting in the u	nderlying cause give	en in Part I.				**	to the cause of death?  Probably 4 Unknown	
of Vital Records,		Completed								24a. Was auto perfe 1 \( \text{Yes}	opsy ormed?	prior t death	autopsy findings available o completion of cause of ? es 2 \( \) No	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	-37		ot 3CLDOA Oth			Check only				
on of	ding Ph n. After th funeral	tion: To	1 ☐ Yes 2 🛣 No  27. Manner of Death 1 🛣 Natural 5 ☐ Pending 2 ☐ Accident investigate	28a. Date of (Month,		28b. Time of Injury	28c. Injun	4 🗆 140	2		Residence 6 Other (Specify) ribe how injury occurred			
Division	l or Attending after death. Director: After I in by the fune	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	Injury - At ho , etc. (Specify	me, farm, str	eet, factory, office			8f. Location ( City or To	(Street and wn, State)	d Number or )	Rural Route Number,	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 11 Certifying F (Check only one) 2 Medical Exa	hysician: To the basiner: On the basiner	is of examinat	wledge, death ion and/or in	n occurred at the time vestigation, in my of	ne, date an pinion, deal	d place, a th occurre	nd due to the	cause(s) date and	and manner place, and d	as stated. ue to the cause(s)	
)	To th within To th	Me	29b. Signature and title of certifier	1 zal	16.1			2654	(MD)		12	111/	nth, Day, Year)	
-			30. Name and address of person who		of death (Item	23а) (Туре,				NAVAL N D 2088			TER	
1	Sta	ite	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signat	ure								

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** MARVIN B. HOUGH 19304 PM DEC 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NA HOSPITAL BALTIMORE AGNES If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Min 1 M 2 F Hours 42 216.74.222 06.26.1964 Director MDUsual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 1 ☐ Yes 2 ( No PARKVILLE Director MD BALTIMORE 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code HAMPTON 21234 2405 BRIDGE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ BLACK 3 Widowed 4 Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 27 is marked other than "natural traumatic event, the Medical Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RUCK DRIVER TAYLOR FARMS 12 TH GRADE NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RICHARD HOLMAN MAE BURTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 19a. Informant's Name/Relationship (Type. Print, B, PARKVILLE MO of Health HOUGH (WIFE 2405 BRIDGE HAMPTON DR KAREN or other permit. Pages 1 a
Department of Hes
Important: if Item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State RANDAUSTOKILI, MD 4 Donation 5 ☐ Other (Specify) MEMORIAL 12.16.06 VAUGHN C. GREENE FUNERAL SERVICE 5151 BAUTO. MATE PIKE, BAUTO. MD 21229 21. Signature of Funeral Service License 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INTRACRANIAL HEMORRHAGE **Physician** & DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 15 YEARS HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Mg Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an as autopsy perform After this certificate 2 X No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Jyotai Punnam, MD P19925 DEC, 12,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 21229 Baltimore 900 S. Caton Avenue Jyothi Punnam, 32. Registrar's Signature 31. Date filed (Month, Day, Year) DEC 1 5

Registrar

HOUGH, MANNIN

2006

		State of Maryland / Department of Health and Mer  1 - State Registrer  Certificate of Death		ene 006	39998
Physi /Med	dical	1. Decedent's Name (First, Middle, Last)  HUDAK  2.	Date of Death Month	Day O'Sar  4c. County of Death	3. Time of Death
Exam Funera Directo	al	Anne Arundel Medical Center  5. Social Security Number 280-18-4534  Annapolis 7. Age (In yrs. last birthday) Yrs.  The description of the property of the prop	Date of Birth (Month, Day, Y	Anne Aru	ndel  plece (State or Foreign untry)
ne Maryland 8e-f show	ector	Usuel Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  Annapolis			10d. Inside City Limits 1 X Yes 2 □ No
Ind 21215-0036  be filed within 72 hours atter death with the Maryland tal Hyglene. d other than "natural", or Items 23s or 28e-1 show event. The Medical Examinar must be notified at	by Funeral Director	10e. Street and Number  2700 South Haven Road  11. Marital Status  1	Ţ	g. Citizen of What Cou United Sta 14. Race - Amer Black, White Specify: W	ites ican Indian,
2121 d within giene.	Completed t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use refired) Food Server		Restaura	
	To Be	to 17. Father's Name (First, Middle, Last) 18. Mother's Name (Fi	lko		ip Code)
Ore, Notes 1 and of Health		Kathryn A. Novicky, Daughter  1133 Rutlandview Avenue,  20a. Method of Disposition  1 X Burial 2 Cremation 3 X Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  12 A 200. 15	9 20	c. Location - City or 1	Town, State
Baltimo permit. Pag Department Importent: i	ouce.	1	ina Yuha	oungstown, asz Funera own, Ohio	1 Home
death certificate be executed  death certificate be executed  e attending physician and and and and and and and and and a	i i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	POU M		Approximate Interval Between Onset and Death
Geath certific death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delive Month	very Day Year
Records, P.O. I he law requires that the de shas been signed by the s ige 2 should be detached it	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac 1  Yes 24a. Was an autopsy performer	24b. Were aut	the cause of death?  bably 4 □Unknown  opsy findings available ompletion of cause of
ISION Of VITAL  Wending Physicien: T death.  ctor: After this certificate y the funeral director, pa	Certification; To Be Co	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home	26. Place of Death Check on one  Cher: 4 Nursing Home 5 Residence 6 Other (Specify)  28c. Injury at Work?  M 1 Yes 2 No		
DIV To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in by	edical Cert		City or Town, S due to the caus at the time, date	se(s) and manner as	stated. to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier  Principle Arena m  29c. License number  21438		Date signed (Month,	6
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	Physici	1. Decedent's Name (First, Middle, Last)  2. Date of D  Month								Year	3. Time of I	Death
	/Medi	cal	Eddie Mae Hammond Dece							2006	6:45	P <sup>M</sup>
	Examir	ner	Vindobona Nursing			7.	n, or Location of De		4c. County	of Death lerick		
	Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	lock Heig	Irs. 8. Date of Bir			ace (State or	r Foreign
	Director		214 - 42 - 287-3 1□M Usual Residence of Decedent	<sup>2⊠ F</sup> 91	Yrs.	Months Day	/s Hours M	July 3	1915	Ken	tucky	
	anylan ehow	-	10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10	d. Inside City	
	Be-f	Directo	Maryland Montgome	ery		Beth					1 Tes	2 X No
	with t	D.	10e. Street and Number 5225 Pooks Hill Ro	od #612N		10f. Zip Code	) 814		10g. Citizen of \		•	
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36	be filed within 72 hours after death with the Maryland tal Hyglene. Id other than "netural", or iteme 23a or 28e-f ehow event, the Medical Exemplas must be notilled at		1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 [X]No Il Yes, Give		fYes, specify C 1 □ Yes 25\$1.N		(Specify Yes or No erto Rican, etc.)	Specify	ck, White, e	tc.	
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Baltimore,	ges 1 and it of Healt if item 2 or other		20a. Method of Disposition 1 □ Burial 2 【XCremation 3 □ Remo		Place of Dispo- cemetery, cren	sition (Name of natory or other p	lace) Doc	ember .	20c. Location -	City or Tov	vn, State	
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Ball	permit. Page Department ( Important: if any injury or once.		21. Signature of Funeral Surfice Licensee	MOO	100 RC	Name and Add	ress of Facility Pumphre	y Funeral , Bethes	. Home/ <sup>B</sup>	ethes	da-Che	≥VY
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	Physician /Medical Examiner	Examiner	shock, or heart failure. List only one collimediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence to (or as a consequence)		thri	ve				Interval Betwonset and De	eath
8760,	cate be executed physician and the burial-transit	ical Exa	resulting in death) Last	Due to (or as a conseq	uence of):						M. Francis St.	
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	Se G	Ď	Part II. Other significant conditions contribu	uting to death bul not res	ulting in the un	derlying cause o	given in Part I.	23e. Did to	bacco use contr		cause of dea	
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ita	Physician: Th this certificate ral director, pag	Be	25. Was —e referred to medical examiner?				26. Place of D	eath Check only or			7	
$\frac{1}{2}$	di di	2	1 ☐ Yes 2 No Hosp	1   Inpatient 2		3LI DOA		Home 5 ☐ Resid	ence 6 Othe	r (Specify)		
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Divis	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify)			28f. Location (S City or Tow	treet and Numbern, State)	er or Rural I	Route Numbe	эг,	
	he Hosp in 24 hou he Funei pletely fil	edicai		On the basis of examina and manner stated.	tion and/or inv	estigation, in my	opinion, death oc	curred at the time, o	late and place, a	nner as stat	ed. he cause(s)	
	To ti To ti Comp	Ň	29b. Signature and title ol certifier			29c. Licer	nse number	à	29d. Date signed	(Month, Da	ay, Year)	
	,		Hira Hira	n N Sharh	nm.	D	51643		12/12/	DE		
	15		30. Name and address of person who complete	eted cause of death (Item	23a) (Type, F	Print)		_	11.00			
	17		31. Date liled (Month, Day, Year)	Thonson	Dy I	reden	da M	D 217	02			
	Sta Registr		DEC 1 5 2006	n N Sharh eted cause of death (Item Thomas Ch Registrar's Signa	LUTS CONTRACTOR	EL P						

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				rtificate of Death	Re	2. No 2 0 0 6 4 0 0 0 0
	Physici	an	1. Decedent's Name (First, Middle, Last)		Day Year 3. Time of Death	
. 4	/Medic		James W. H.	art  4b. City, Town, or Location of Death	Decembe	r 10,2006 8:00P <sup>M</sup> 4c. County of Death
	Examin	er	7727 B & A Blvd.	Glen Burnie		Anne Arundel
	Funeral		Social Security Number     6. Sex    7. Age (In yrs. last birthday)		8. Date of Birth	O Dietheless (Ctets - Ferri
п	Director		037-32-1443 1 <sup>™</sup> 2□F 58 Yrs.	Months Days Hours Min.	June 25,	1948 RI
	and t		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
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	n 18a	Director	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Country?
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	er dea tems ner mi	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs afte	by F	1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No If Yes, Give 3 □ Widowed 4 ☑ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White
9200-91717	be filed within 72 hours after death with the Maryland and thylgiene. All Hygiene, ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted	15. Decedent's Education 16a, Dece	dent's Usual Occupation	16	6b. Kind of Business/Industry
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7.	led wi lygien ner th	Co		istrative Manger		Automotive
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3a 1	permit. Depart Import any inj once.					Funeral Home, P.A.
	= 4 0			Second Avenue SW		
			23a. Part1. Soler the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arres	t, Approximate Interval Between Onset and Death
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מ	death e atte	hysician/M	in the past 12 months? 1□Live birth 2□Fetal death 3L 1□Ves 2□No 4□Pregnant at time of death 5[	Ectopic pregnancy Other (specify)		Month Day Year
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<u>,</u>	res m igned be de	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
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records	hast hast je 2 s	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	n: In ficate or, pag		25. Was case referred to medical		performe 1□ Yes /21	
> :	/sicial	To Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatien	Othor	(Check only one)	
IVISION OF	ig Pring Fring ter this neral of		27. Manner of Death 28a. Date of Injury 28b. Time of	/ Terrarang no	28d. Describe how	ce 6 Other (Specify) injury occurred
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Á	or And fter de Sirect in by t	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
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	io ne neoppial or Atendang Prysician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	To th Comp	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, Day, Year)
			James Bott all	HAAAAA		12/14/06
	70		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) GP D		0
	\ 		31. Date filed (Month, Day, Year)  31. Registrar's Signature	304 Glen Bur	NIE, M	U21061
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